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U.S. President's Emergency Plan for AIDS Relief

Closing the Gap for Children: PMTCT, Pediatrics, and OVC

PEPFAR Mozambique | March 9, 2022

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19 YEARS OF SAVING LIVES THROUGH AMERICAN GENEROSITY AND PARTNERSHIPS

PMTCT Advances, Challenges and Strategies

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Successes and Current Gaps in the PMTCT Cascade

Clinical cascade WLHIV 15+yo

- Increasing retesting for HIV Negative PLW
- Steady growth in WLHIV TX_CURR

EID cascade

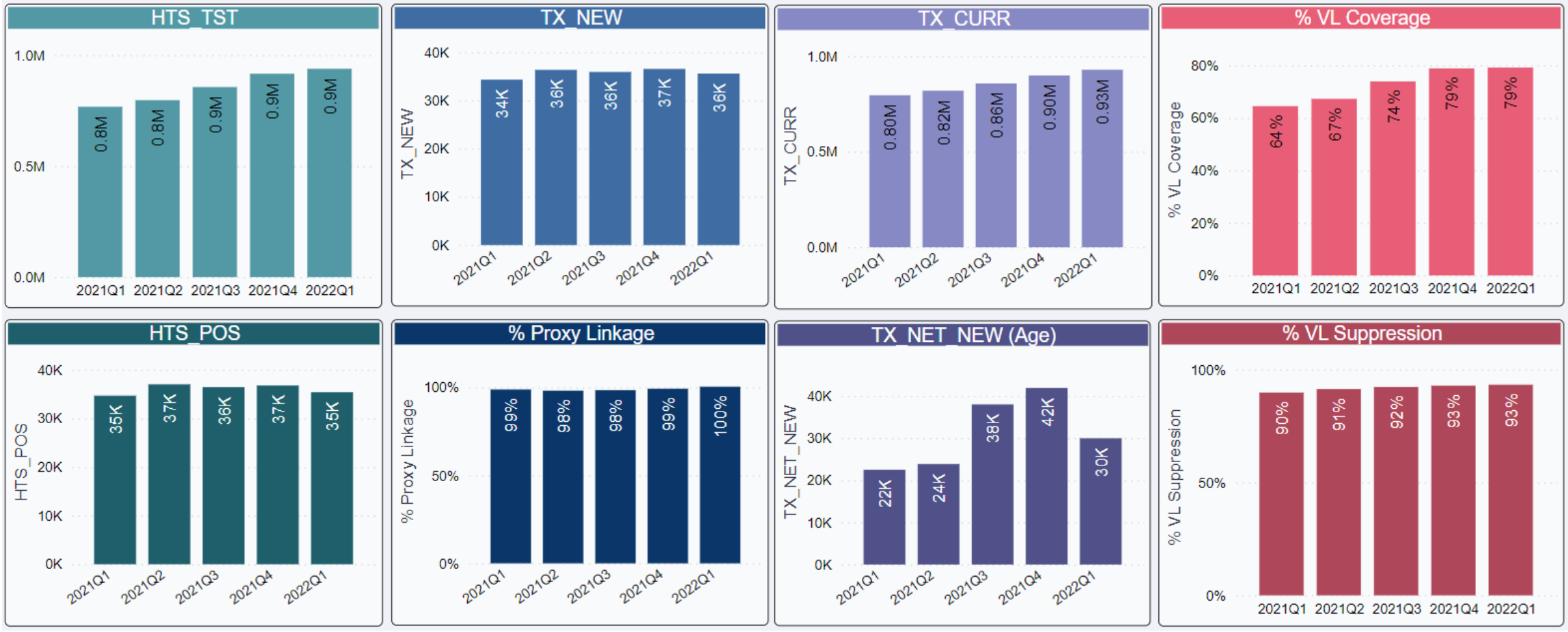
- After multi-year improvement, stalled EID positivity over past three quarters
- Robust EID coverage
- Infant linkage improving

Viral load coverage and suppression

- Progress slow for VLC and VLS in PW
- Improvements in VLS for BFW

Clinical Cascade for WLHIV 15+yo Demonstrates Steady Growth

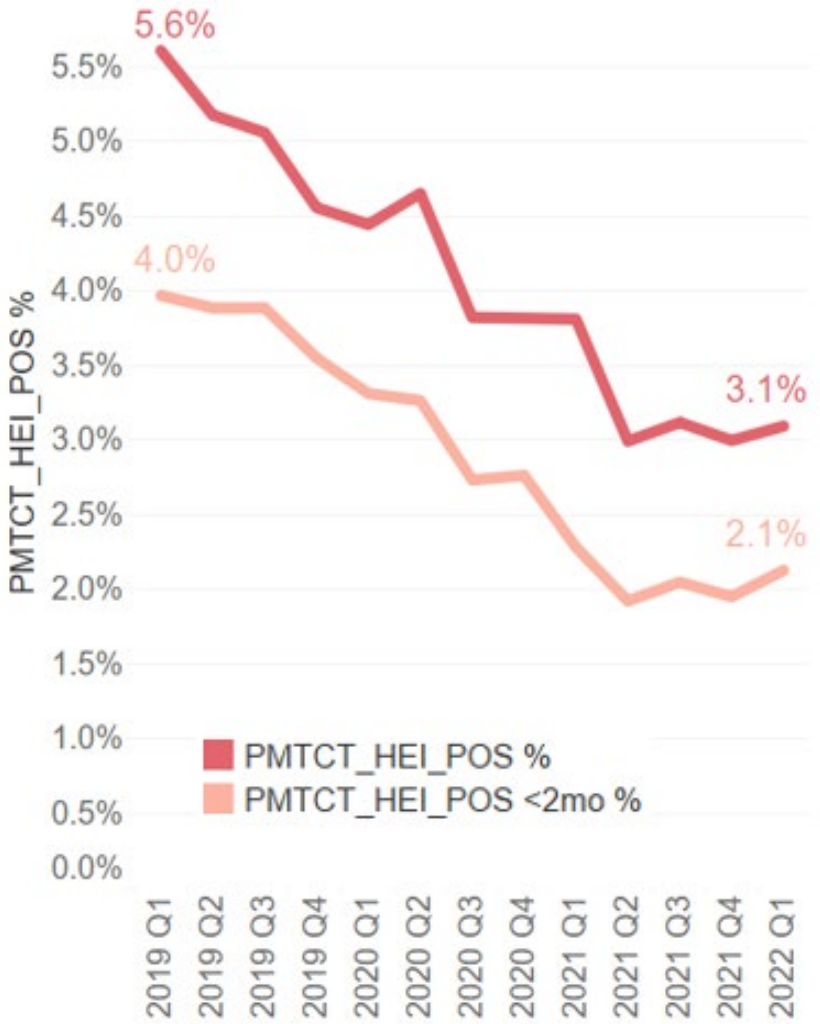
Clinical Cascade Summary WLWHIV 15+ yo, AJUDA Sites, Q1 2021 – Q1 2022



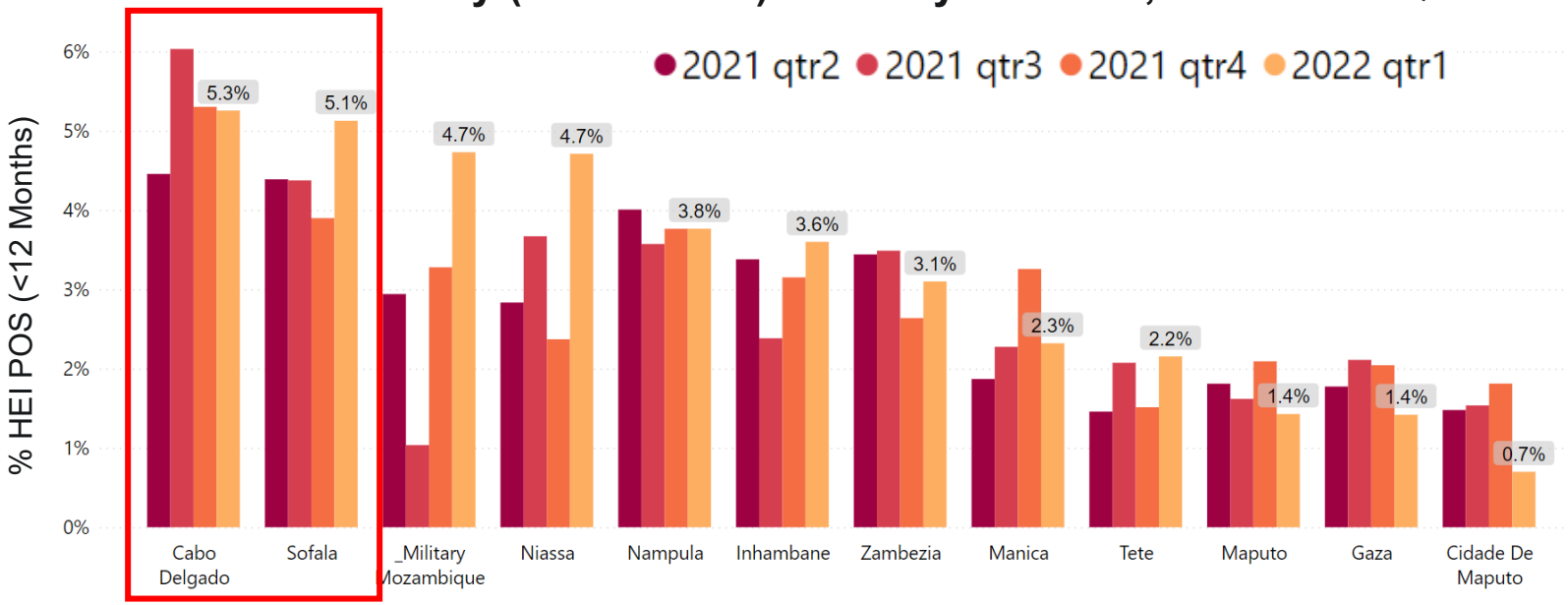
- **Overall clinical cascade growth for WLHIV from Q1 2021 to Q1 2022, with slowed case finding gains in Q1**
- VLC coverage improving, but further progress needed, in and out of ANC
- VLS consistently ≥90% since Q1 FY2021 and currently at 93%

PMTCT Program in AJUDA Sites with Multi Year Progress, but Uneven Recent Provincial Gains

HEI positivity trend AJUDA sites, 2019-2022



HEI Positivity (<12 months) Trend by Province, FY21-FY22 Q1



Consistent PCR positivity decrease nationally over the last 3 years, but progress stalled in past three quarters, including Q1

Provincial level challenges impacting progress in Q1:

- *Maputo Province, Maputo City and Gaza* with less than 2% positivity
- *Cabo Delgado and Sofala* with 12-month infant positivity >5%
- *Cabo Delgado* and *Nampula* with higher positivity among IDP mother-baby pairs impacting provincial results

Excellent results require excellent fidelity in implementation

Reinforcing PMTCT Programming for Displaced HIV+ PLW

IOM Displacement Tracking Matrix (DTM)
November 2021

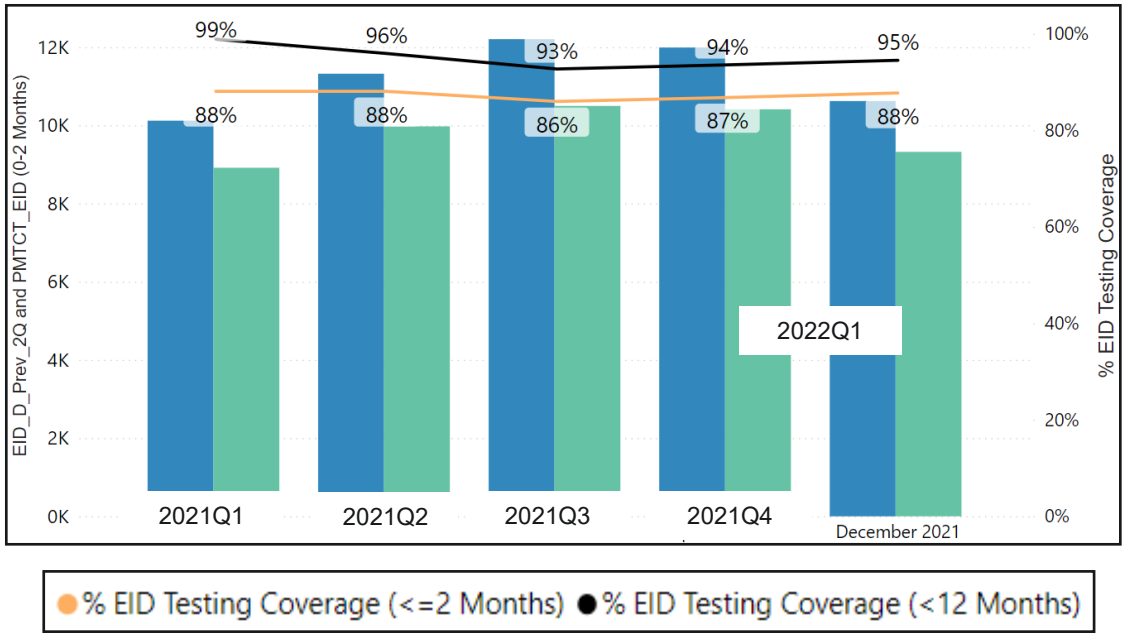
Province	Individuals	Adult Men	Adult Women	Children	% Children
Cabo Delgado	663,276	138,878	193,659	330,739	50%
Nampula	68,951	13,594	16,768	38,589	56%
Niassa	1,604	285	390	929	58%
Zambezia	1,265	250	290	725	57%
Sofala	153	34	42	77	50%
Inhambane	85	20	38	27	32%
Total	**735,334**	**153,061**	**211,187**	**371,086**	**50%**

- Integrated mobile brigades with ANC and VL/EID testing, MM support
- GBV screening (LIVES) and case management capacity for MM and clinicians caring for IDP's
- 3MDD for PLW in emergency settings
- Mentor Mother teams in IDP communities—CDG and Nampula
- Patient passports to ease transfer for highly mobile populations

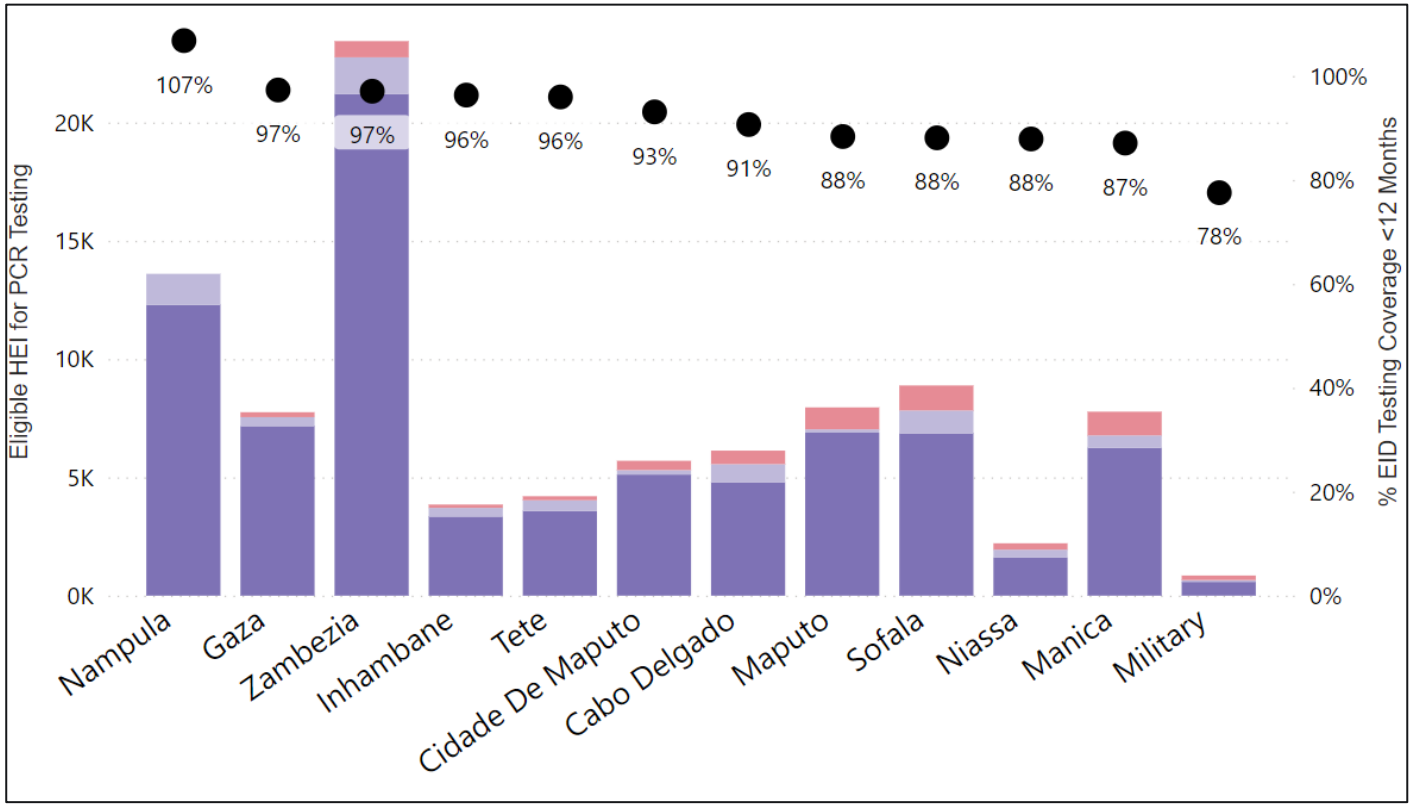
EID Testing Coverage Robust in Most Provinces

EID Testing Coverage 0-12 months, AJUDA sites

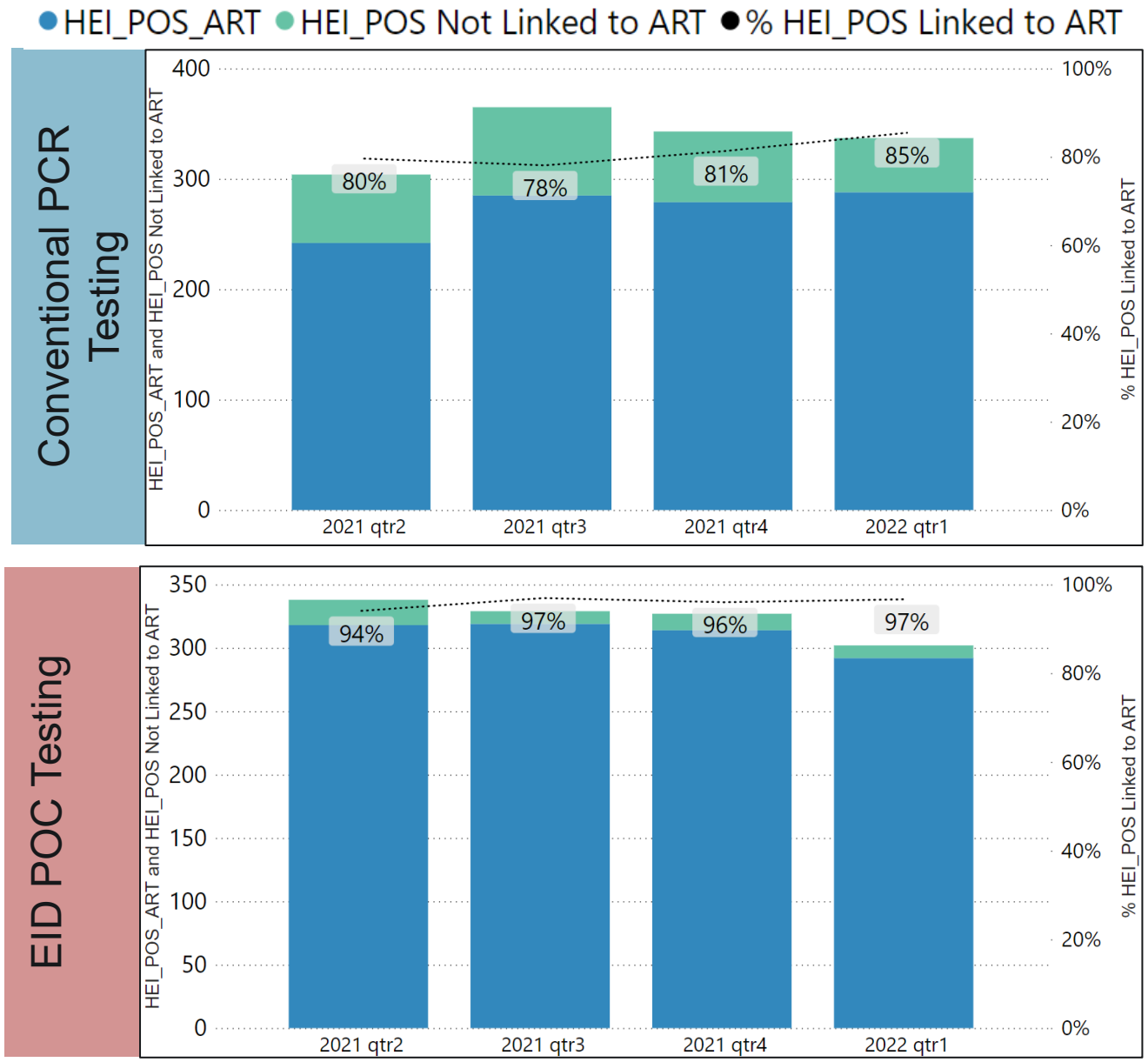
(Proxy denominator two quarters prior)



EID Testing Coverage, AJUDA sites (Q2 FY21 – Q1 FY22)



Significantly Better Infant Linkage to Care in Health Facilities with EID POC



Footprint

- EID POC at 135 sites, with plan for expansion to 21 additional sites in CO21
- 42% of all EID tests at EID POC sites in Q1
- 21% of AJUDA sites with EID POC in place, serving 49% of HIV+ PW at AJUDA sites

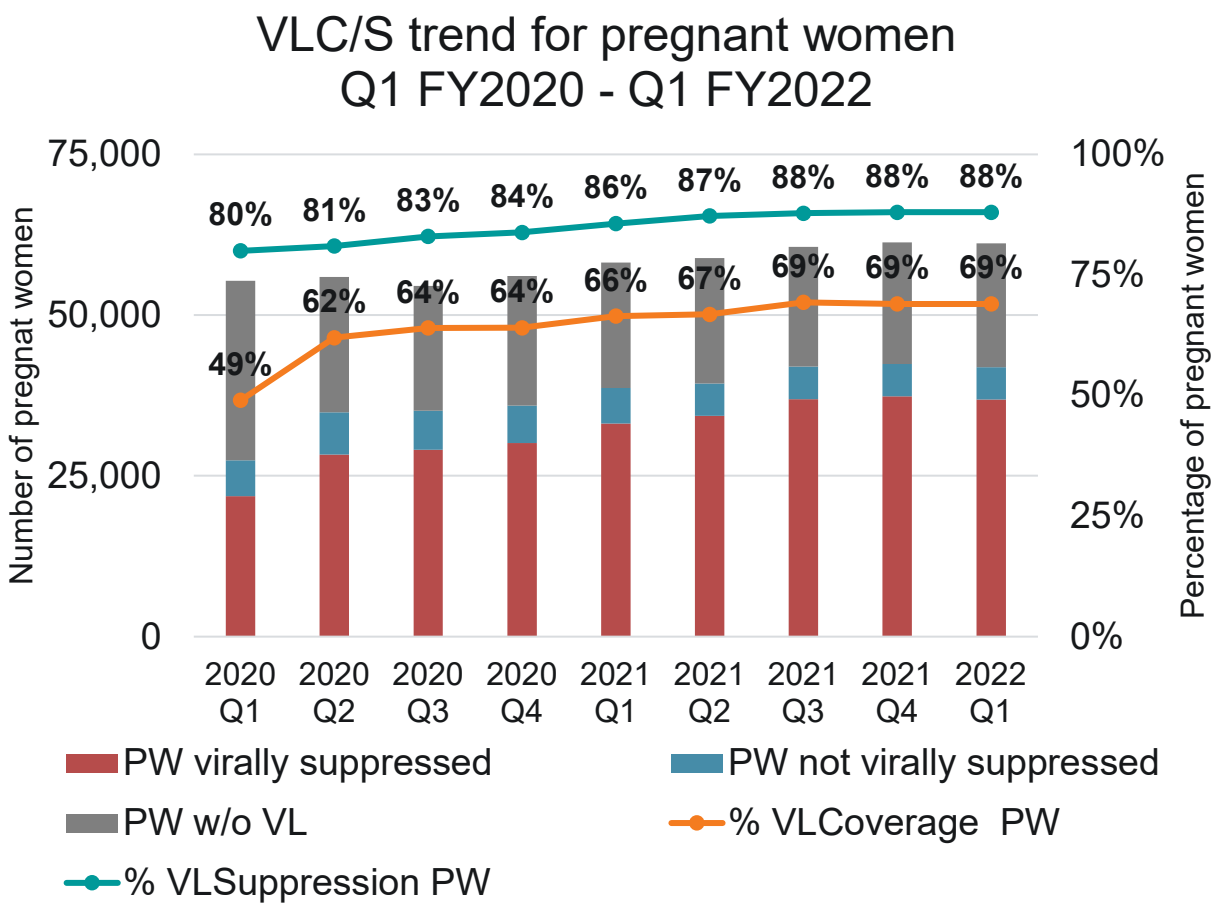
Achievements

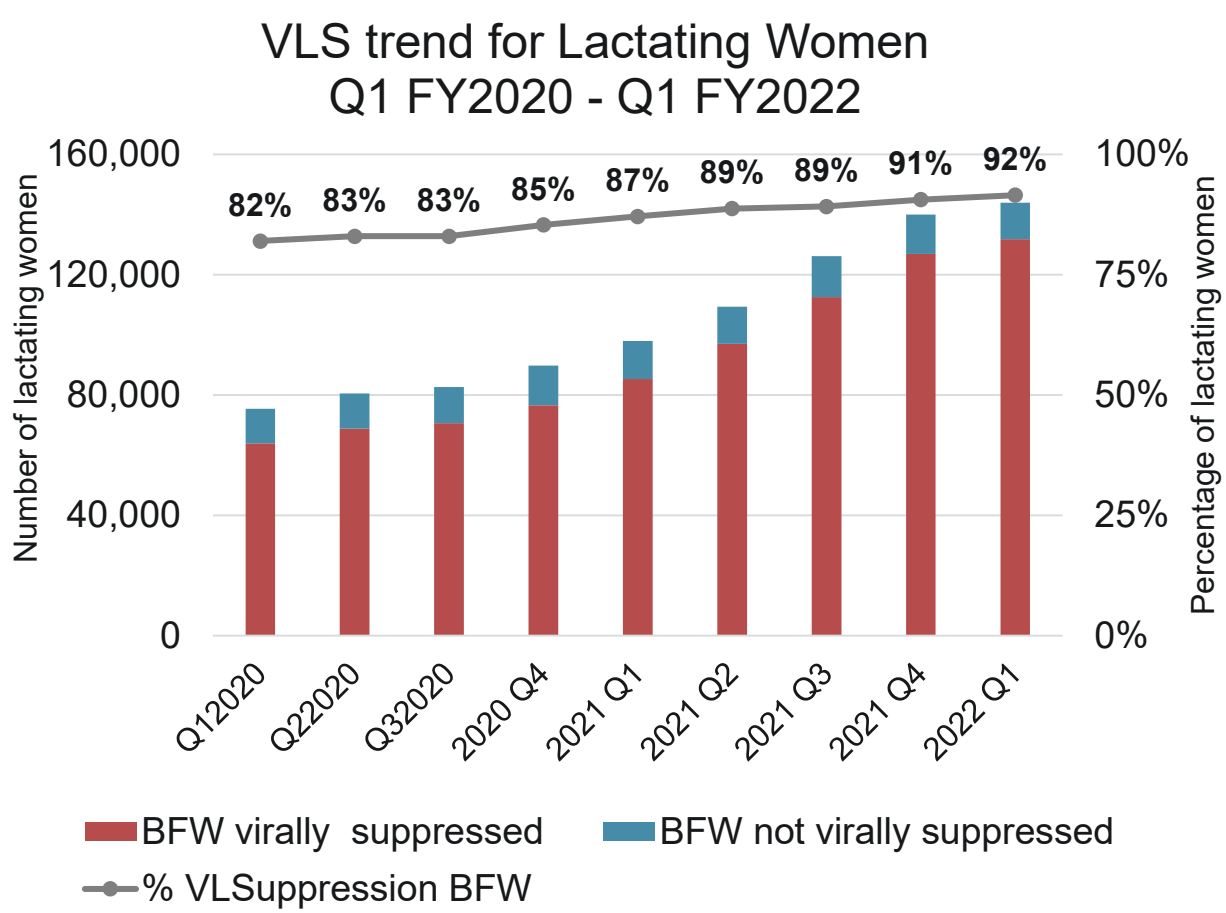
- Substantial increase in linkage to ART from Q2FY2021 to Q1FY2022:
  - All AJUDA sites: 87% to 91%
  - Conventional PCR sites: 80% to 85%
  - POC testing sites: 94% to 97%

Strategies driving improvement

- Active tracking of HIV+ infants by mentor mother/APSS teams for linkage to care
- Systematic review of non-linked cases to provide additional support for families at community-level

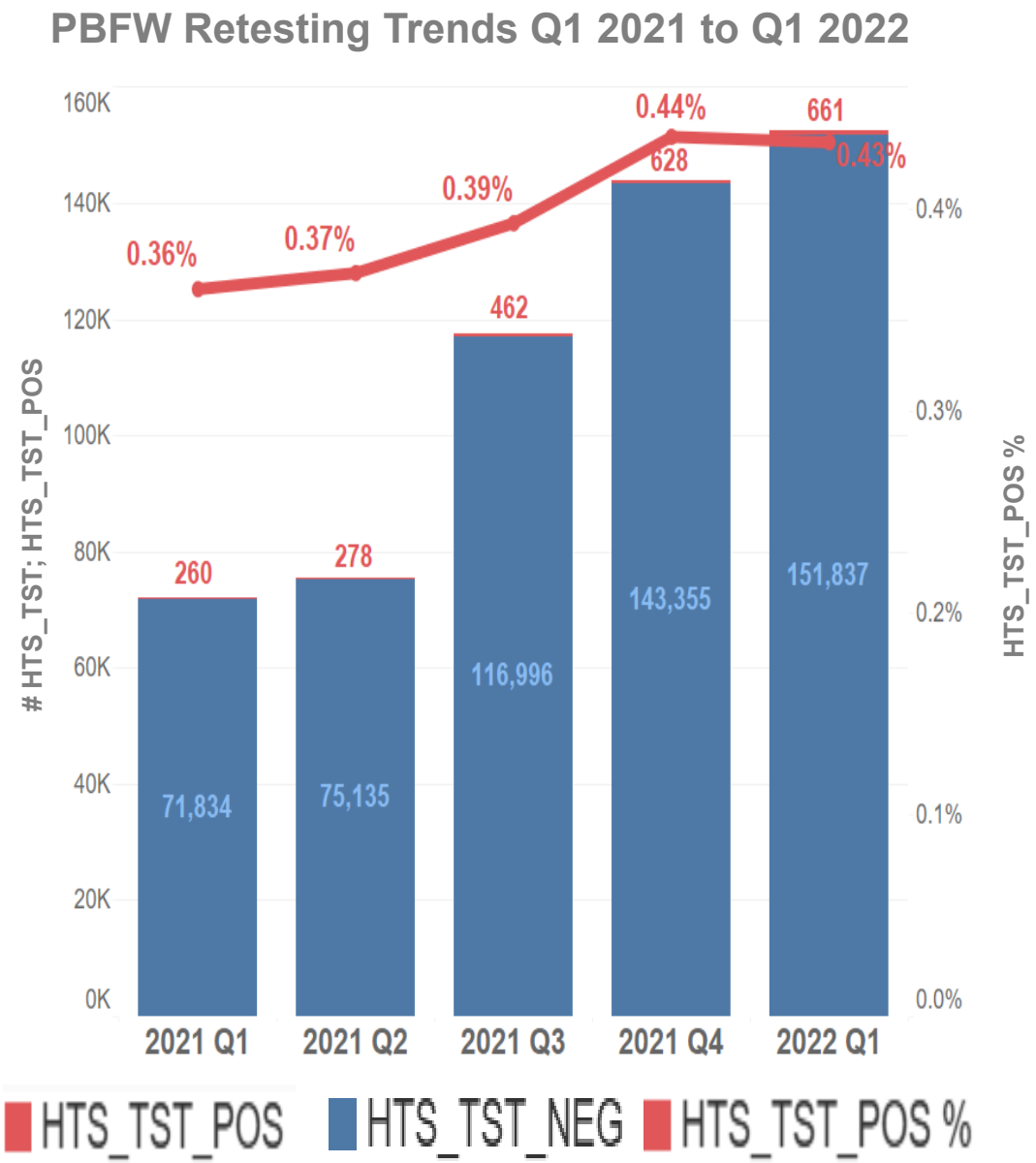
Viral Load Suppression Slowly Climbing for Breastfeeding Women





- Enhanced VL monitoring will be one focus of intensified PMTCT mentoring
- VL multiplexing launching in March 2022 in Zambezia and Nampula
- Revising site level SOP's to improve query/data quality to accurately designate pregnancy

Increasing Retesting HIV Negative PLW



- Spectrum estimates 40% of new pediatric infections linked to HIV incident infections in PLW
- MoH retesting circular released in Jan 2022
- Post ANC1 retesting with stable yield ~ 0.4%
- COP21 evaluation of MOH retesting screening tool with aim of focusing testing resources on highest at-risk HIV negative LW
- PrEP roll out and retesting program offer integrated service delivery

Pediatric & Adolescent Programming Status and Strategies

Successes and Current Gaps in Pediatric and Adolescent Clinical Cascade

Case identification

- Case identification challenges
- Stagnant TX_NEW

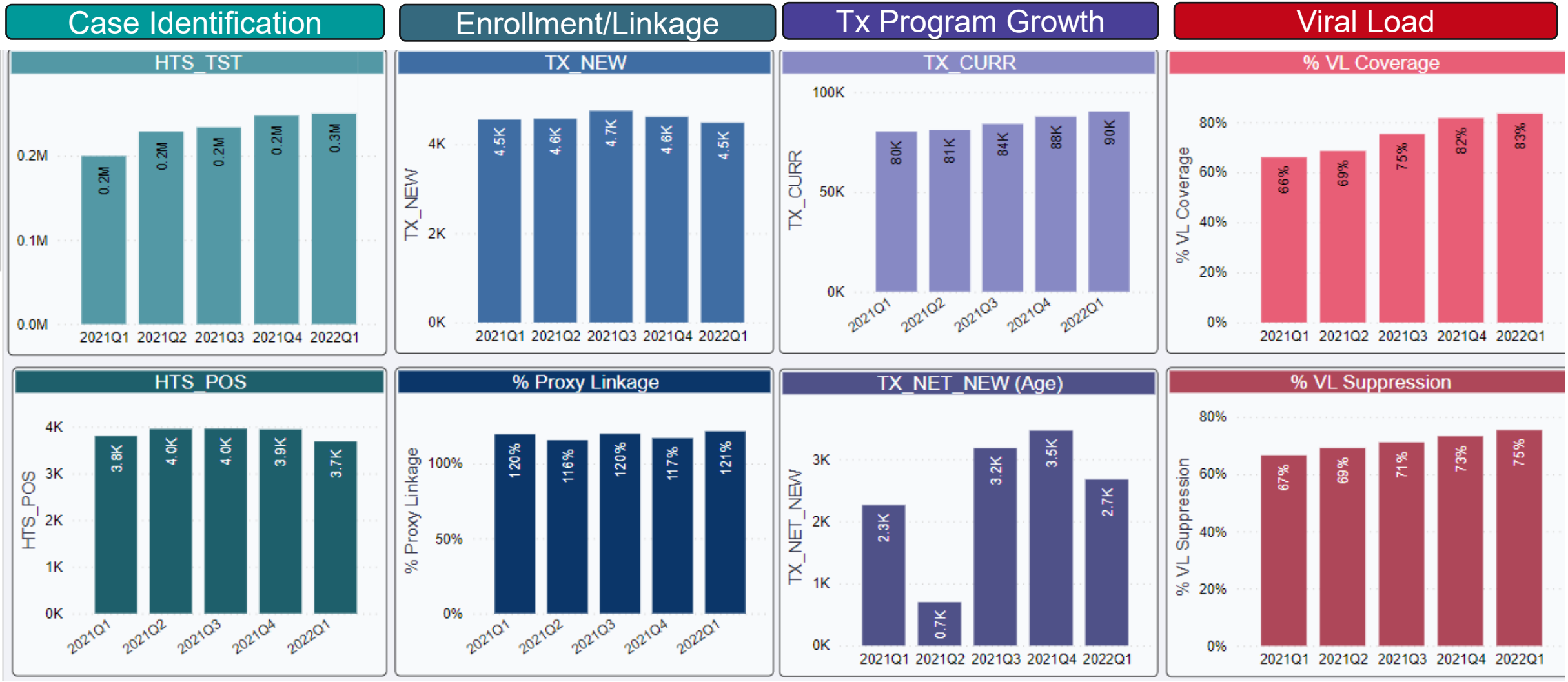
Retention and quality of care

- Steady growth in pediatric TX_CURR
- High pediatric TX_ML in North/Central Province and among young children and AGYW

Viral load coverage and suppression

- Improvements in VLC
- Though improving, low VLS among CLHIV and adolescents

Pediatric Clinical Cascade Demonstrates Steady Program Growth

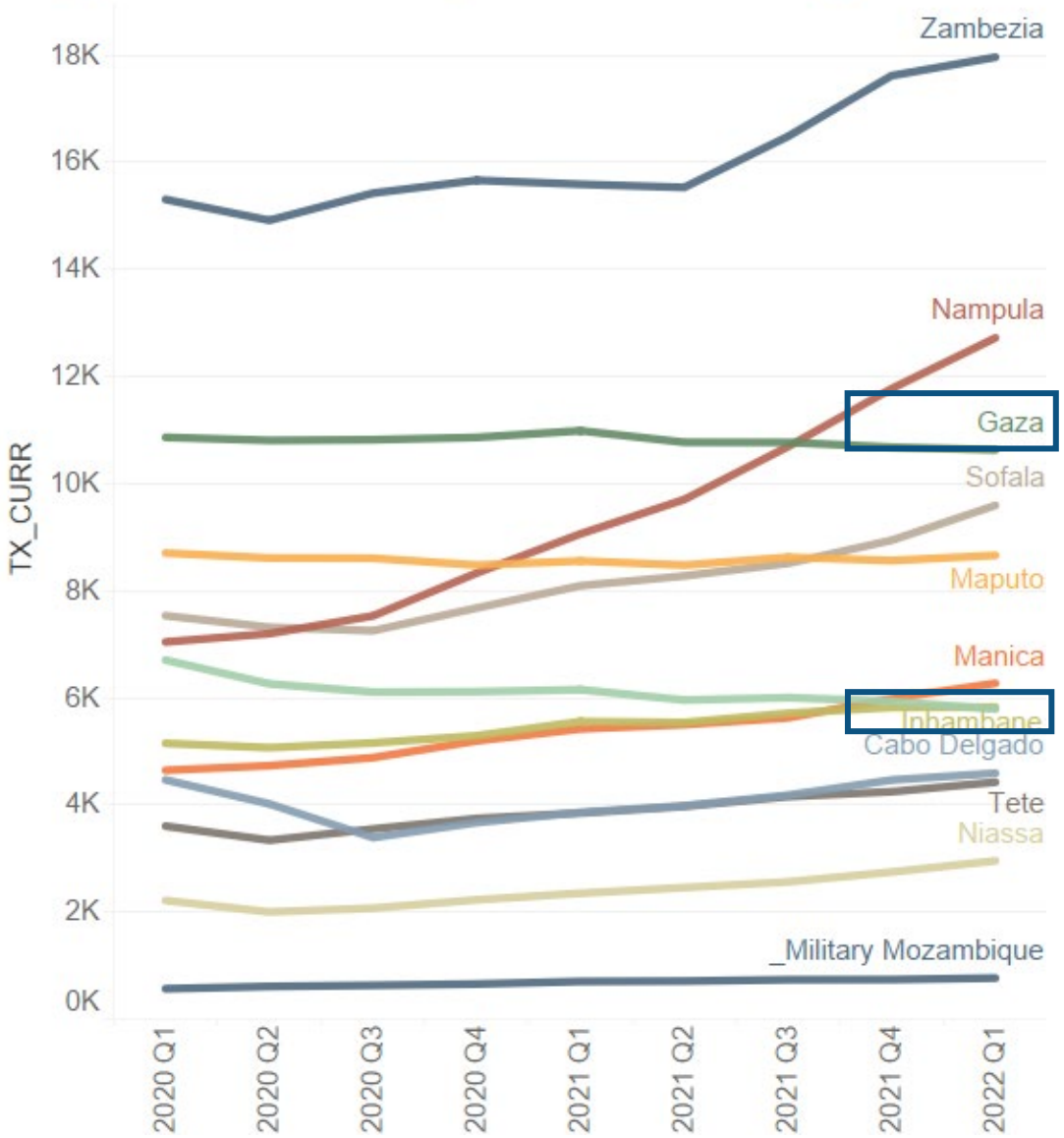


- Stable case finding with steady pediatric program growth driven by reduction in IIT
- Improvements in VLC and VLS for CLHIV, but youngest children lagging in AJUDA sites

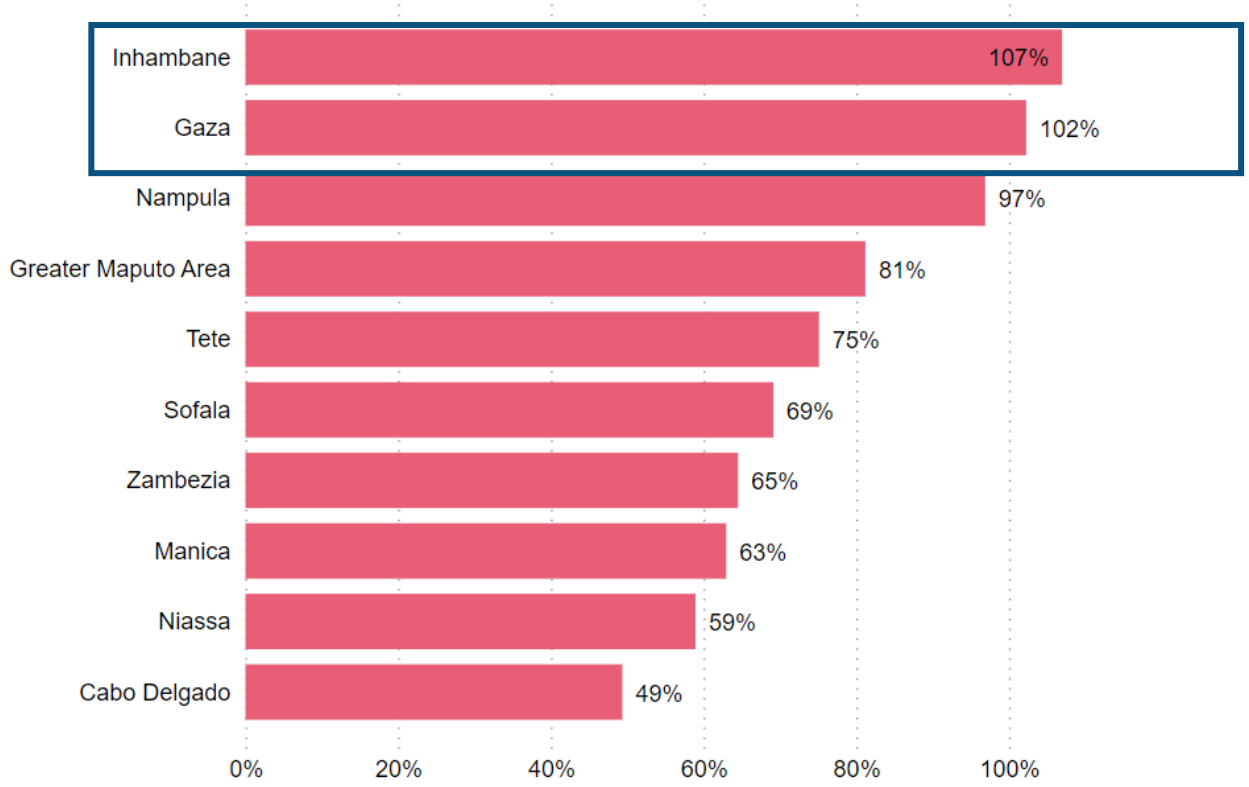
**VLC/S only reported for EPTS sites*

Pediatric Program Growth Across All Provinces

TX_CURR Trend by Province < 15 yo



% of ART coverage among CLHIV (0-14) by province



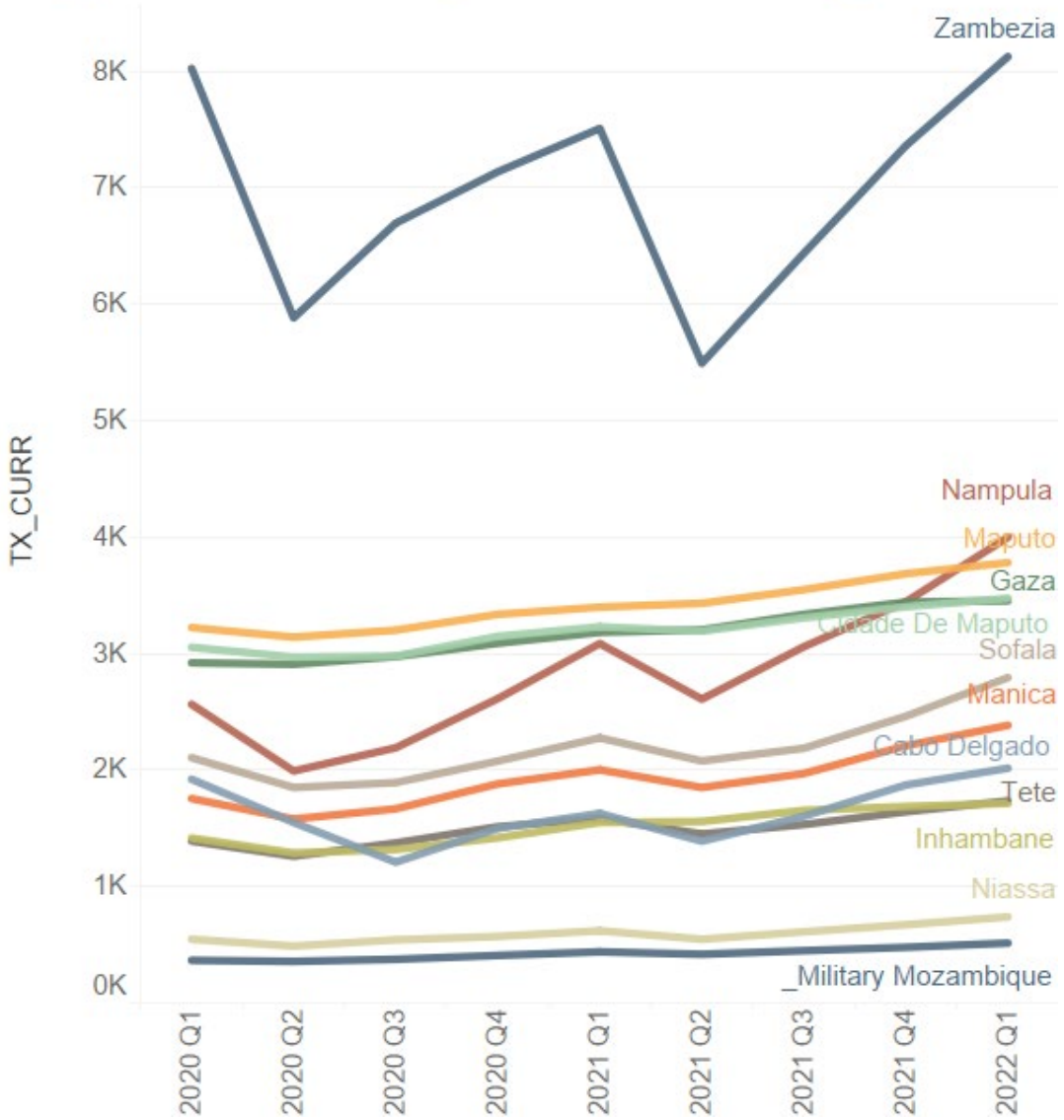
*** Coverage Numerator:** Number on ART, TX_CURR MER Q1 2022

*** Coverage Denominator:** Estimated PLHIV, "PLHIV.T_1" (Spectrum v6.14 with Naomi Sept 2022)

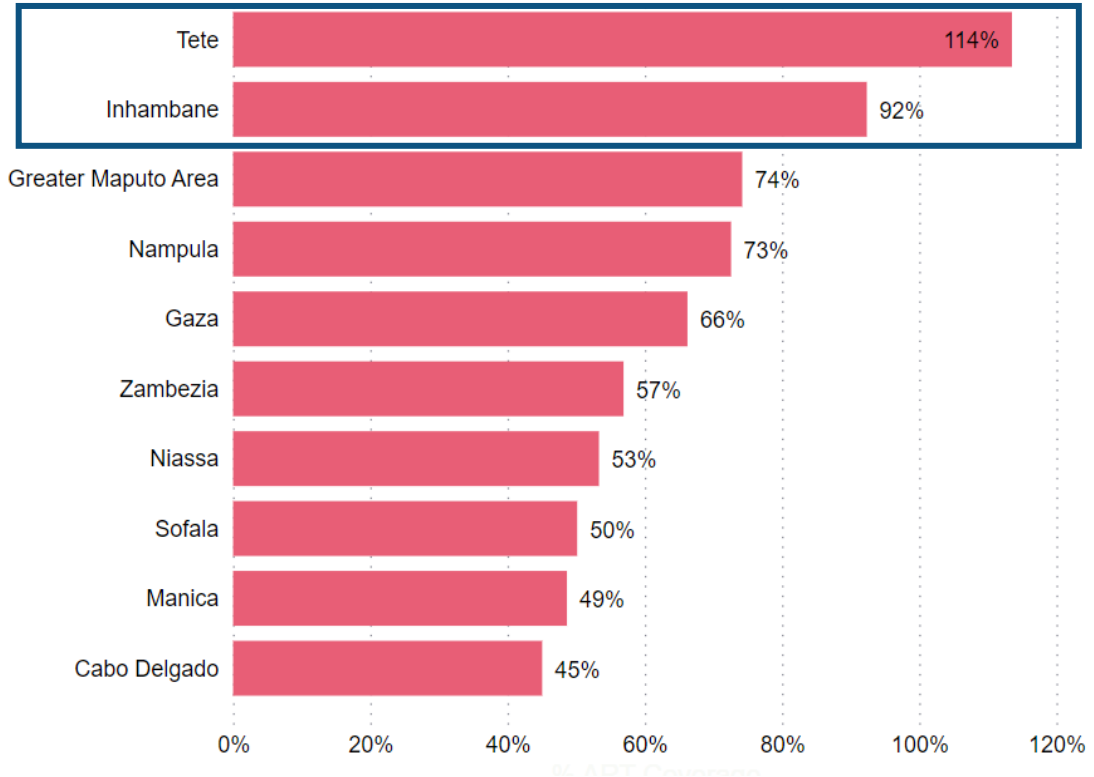
- Pediatric program growth in all provinces
- Modeling suggests that Inhambane and Gaza reaching saturation for pediatric populations

Adolescent Program Growth but Low ART Coverage for Most Provinces

TX_CURR Trend by Province 15-19 yo



% of ART coverage among ALHIV (15-19) by province



*** Coverage Numerator:** Number on ART, TX_CURR MER Q1 2022

*** Coverage Denominator:** Estimated PLHIV, "PLHIV.T_1" (Spectrum v6.14 with Naomi Sept 2022)

- Adolescent program growth in all provinces
- All provinces except Tete and Inhambane with estimated ART coverage <75%

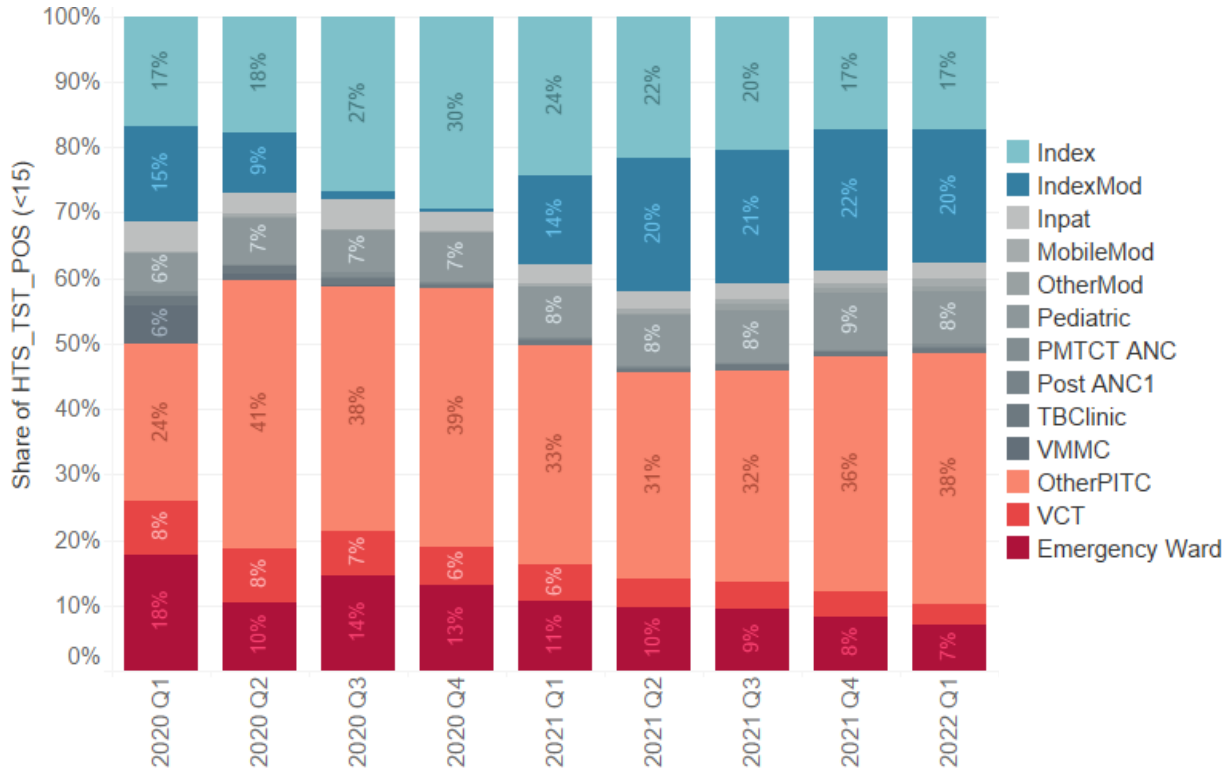
Improved Identification of CLHIV via ICT but Many Children Still Found When Sick

Pediatric HTS Summary by Modality 2022 Q1

	HTS_TST	HTS_POS	* HTS_NNT	Yield %
Index	22,218	634	35	2.9%
VCT	5,220	115	45	2.2%
MobileMod	1,967	41	48	2.1%
OtherPITC	74,680	1,413	53	1.9%
TBClinic	1,920	34	56	1.8%
Inpat	5,635	94	60	1.7%
OtherMod	1,901	29	66	1.5%
Emergency Ward	21,686	261	83	1.2%
IndexMod	70,206	754	93	1.1%
PMTCT ANC	1,633	16	102	1.0%
Pediatric	42,982	294	146	0.7%
Post ANC1	363	2	182	0.6%

* NNT – Number needed to test to identify one CLHIV

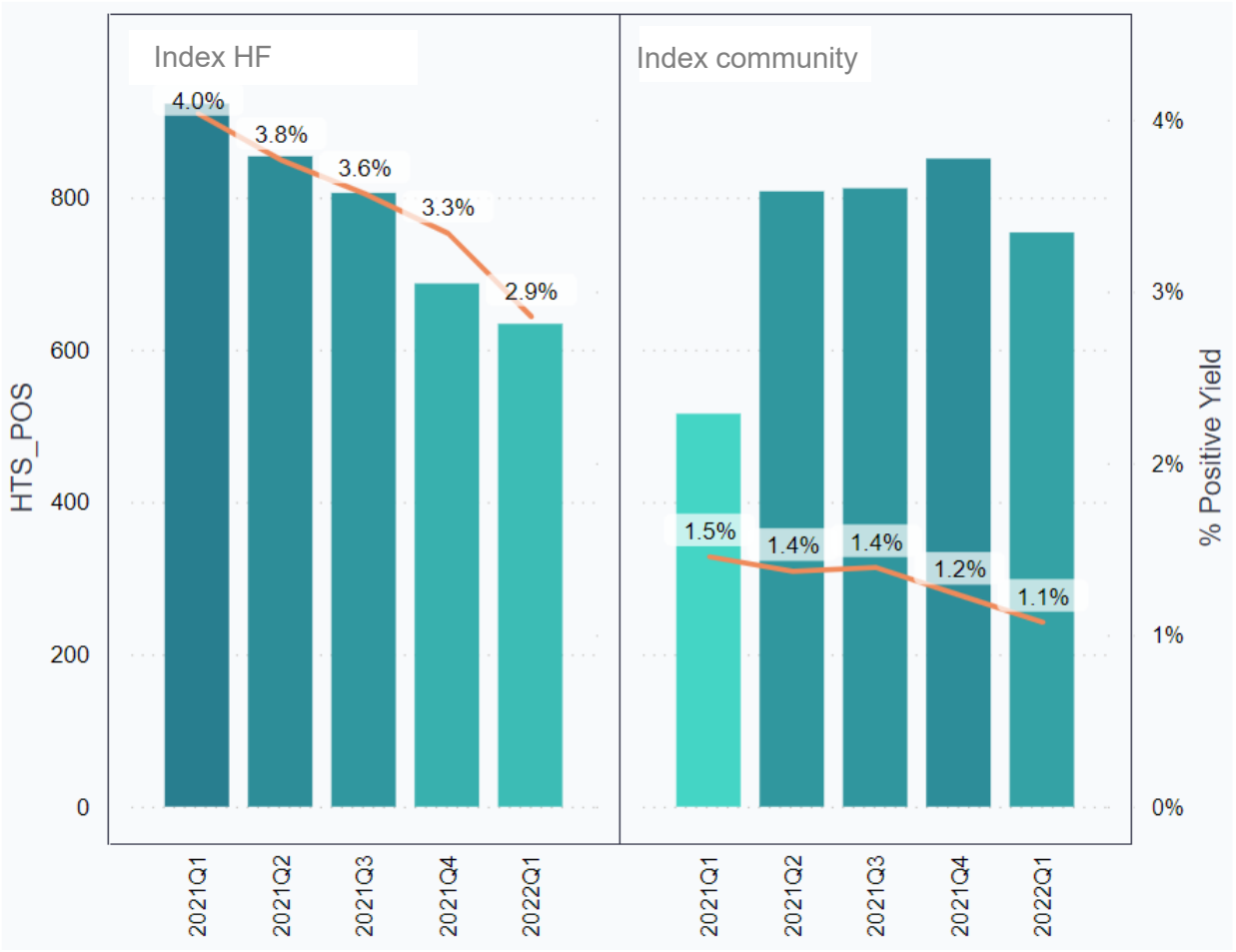
% Share of Total HTS_POS by Modality (<15) 2022 Q1



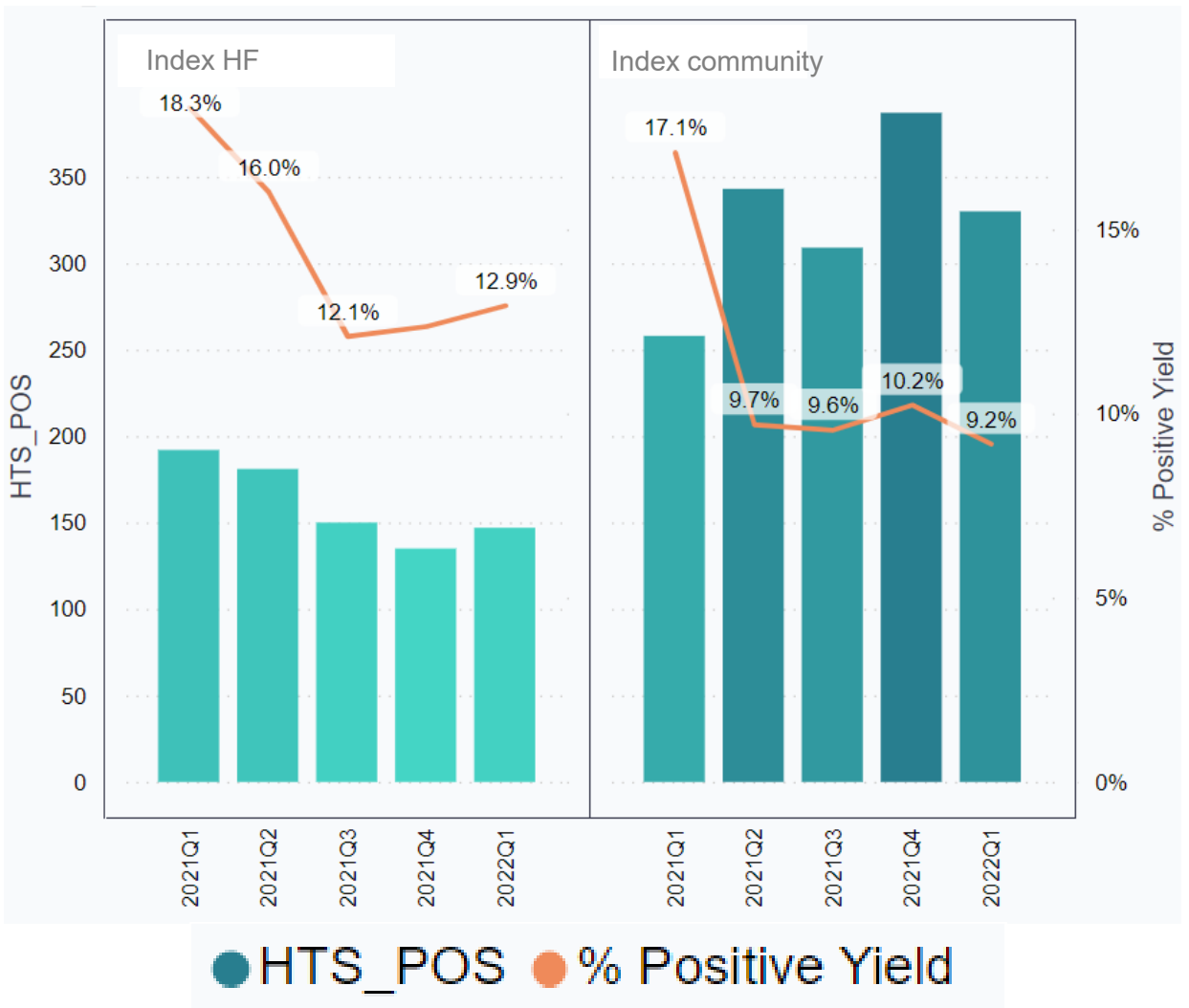
- Highest testing yields among Index, VCT and community-based testing modalities
- **Approximately 59% of children in Q1 identified when <u>already sick</u>**

Decreasing Yield in Pediatric ICT Requires Pivot for Better Focus

HTS POS and yield by index case modality, children <15

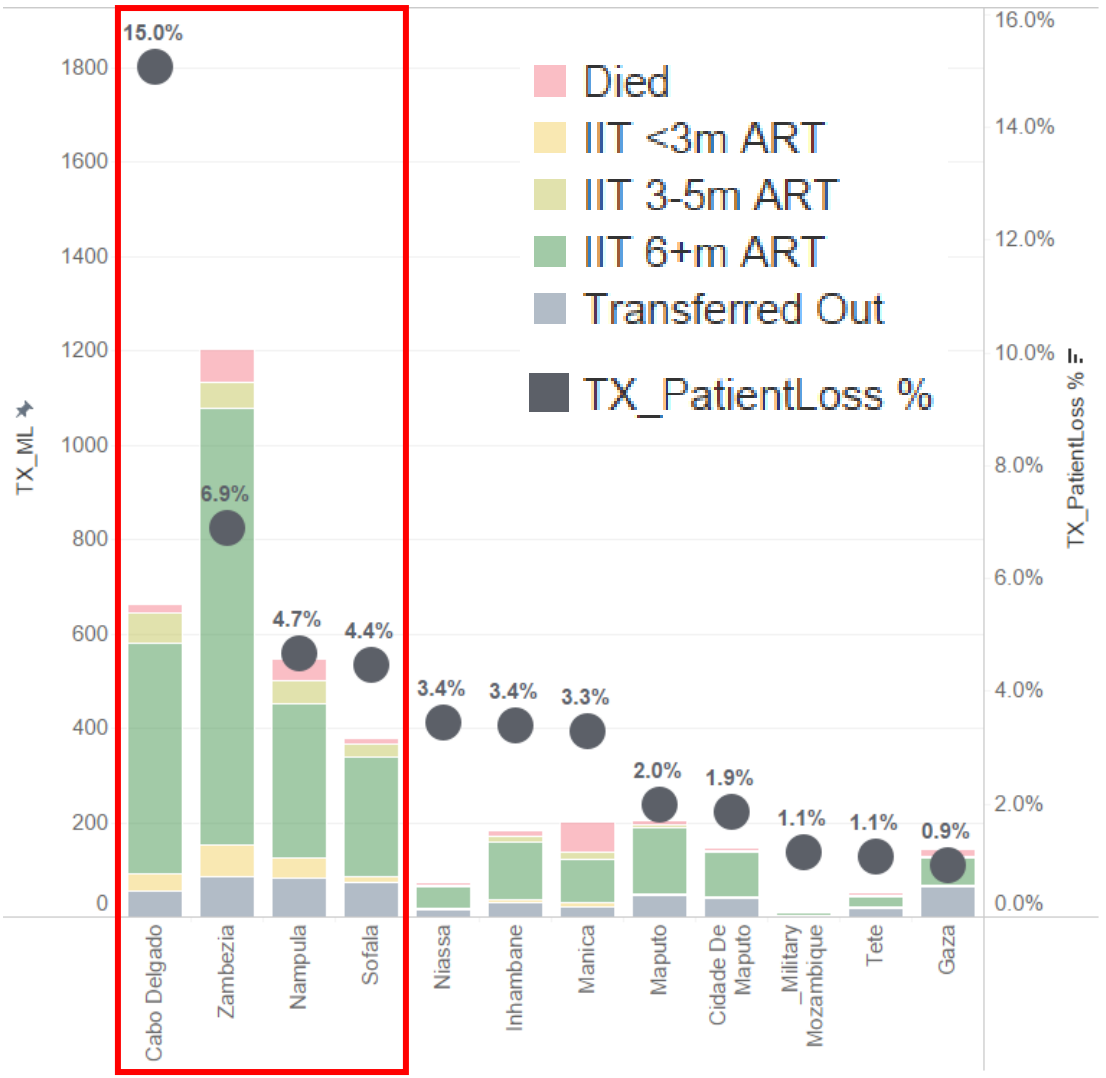


HTS POS and yield by index case modality 15-19 yo



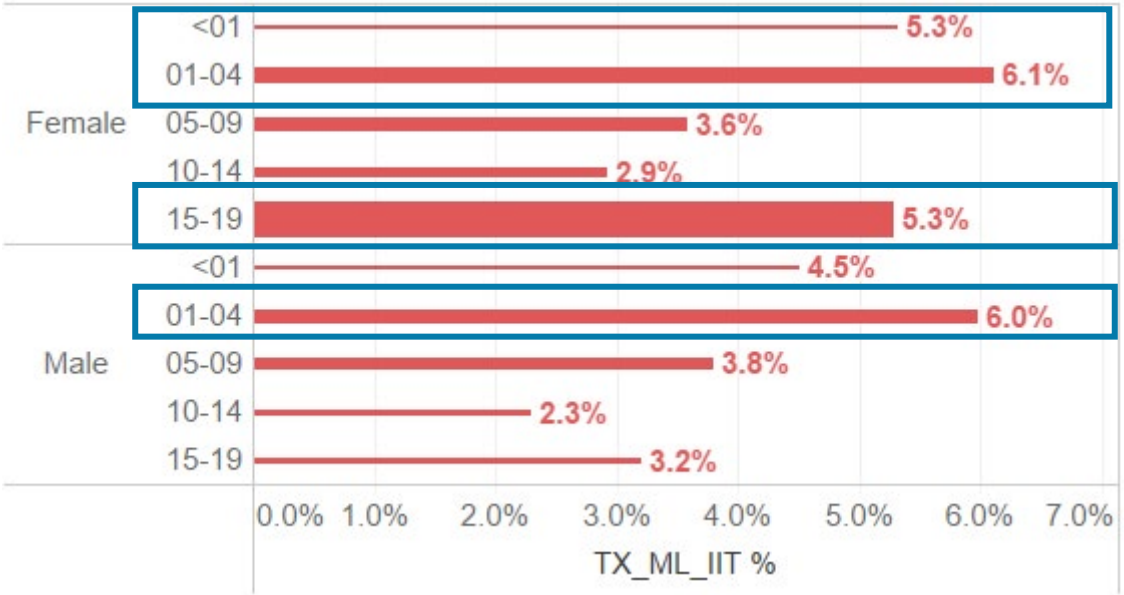
Highest Pediatric Loss in North/Central Provinces, Young Children and AGYW

Pediatric TX_ML and Patient Loss by Province (2022 Q1)



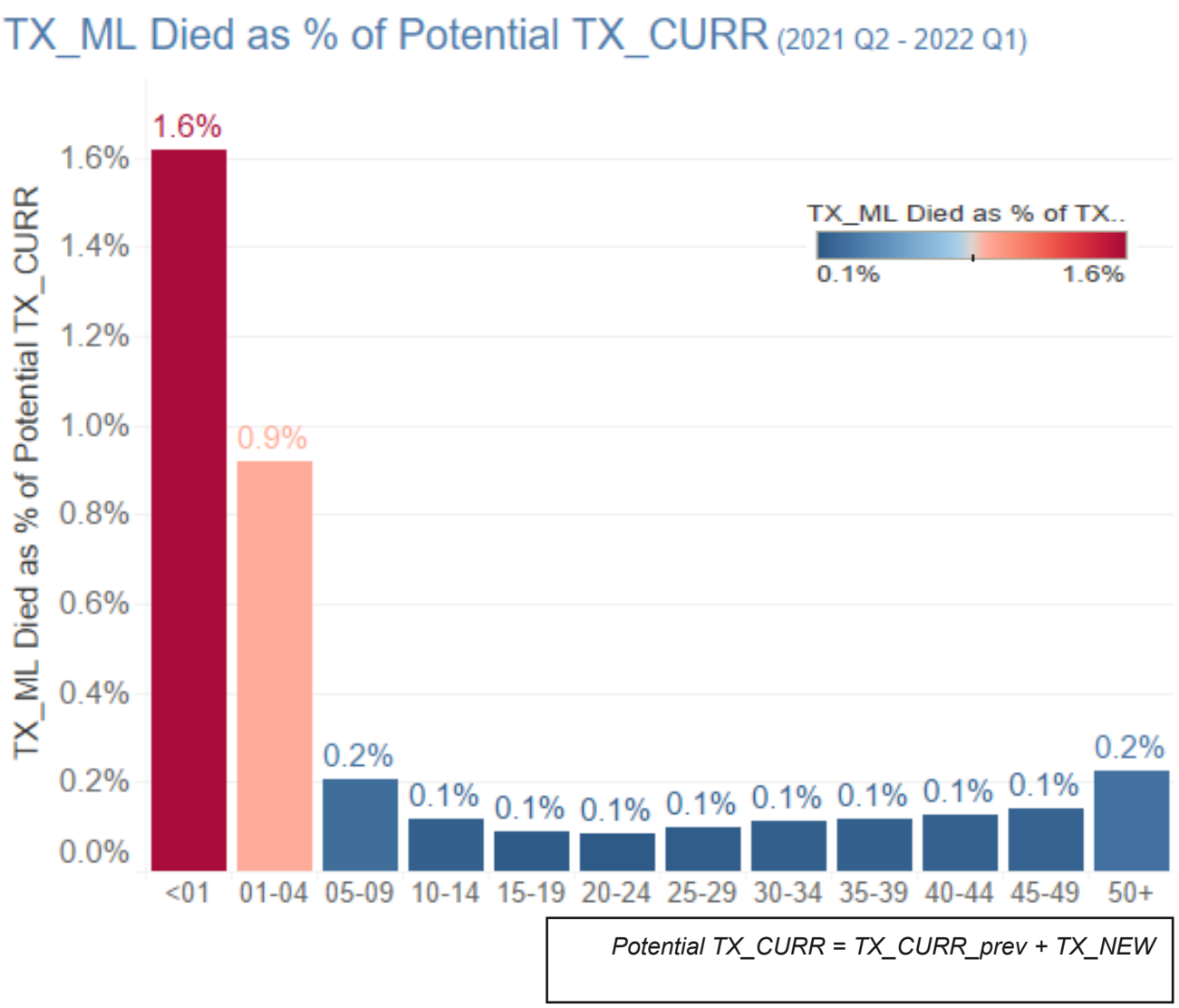
- Cabo Delgado, Zambezia, Nampula, Sofala with highest % and # of pediatric patient losses
- Children 0-4 and female adolescents 15-19 with highest % and # of peds IIT

IIT by Sex & Age (2022 Q1)



TX_PatientLoss % = TX_PatientLoss / Potential TX_CURR
TX_PatientLoss = TX_ML – TX_ML Transferred Out
Potential TX_CURR = TX_CURR_prev + TX_NEW
IIT=Interruption in treatment

Expanding Support for Children with Advanced HIV Disease

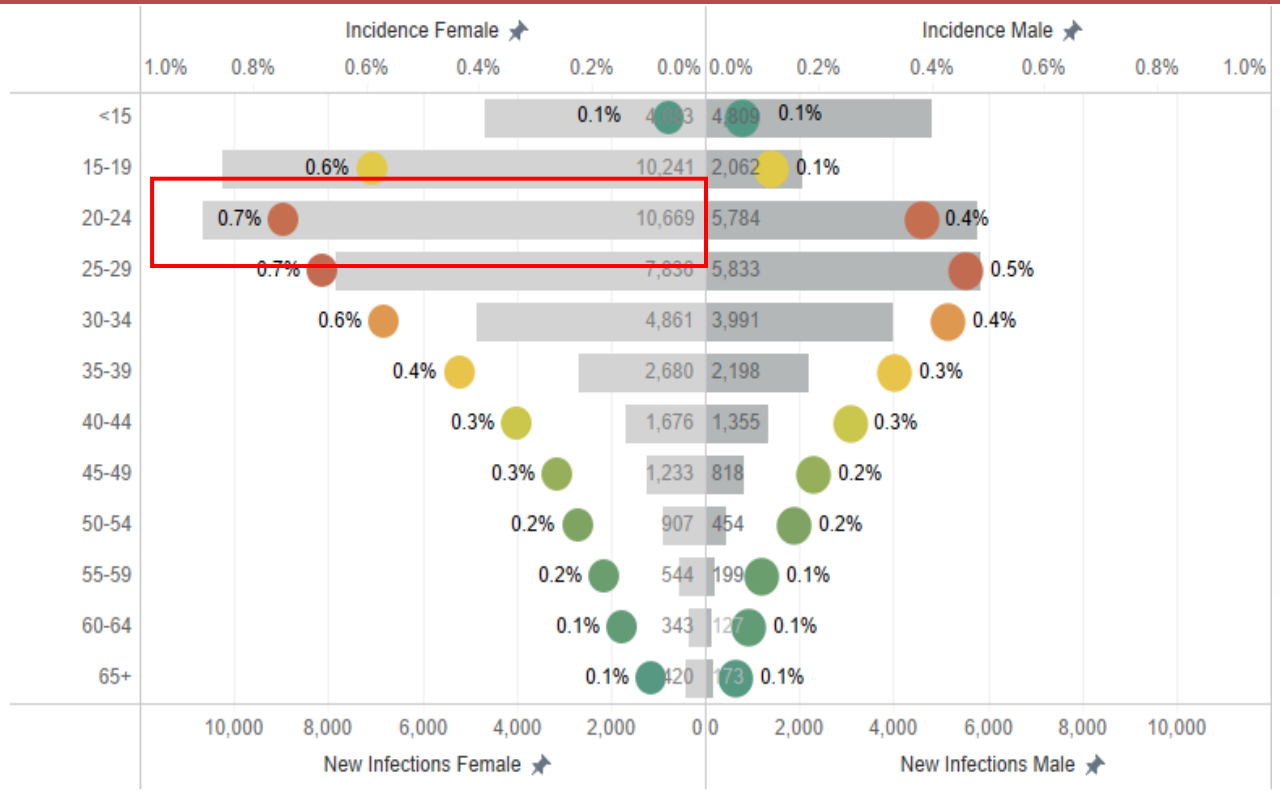


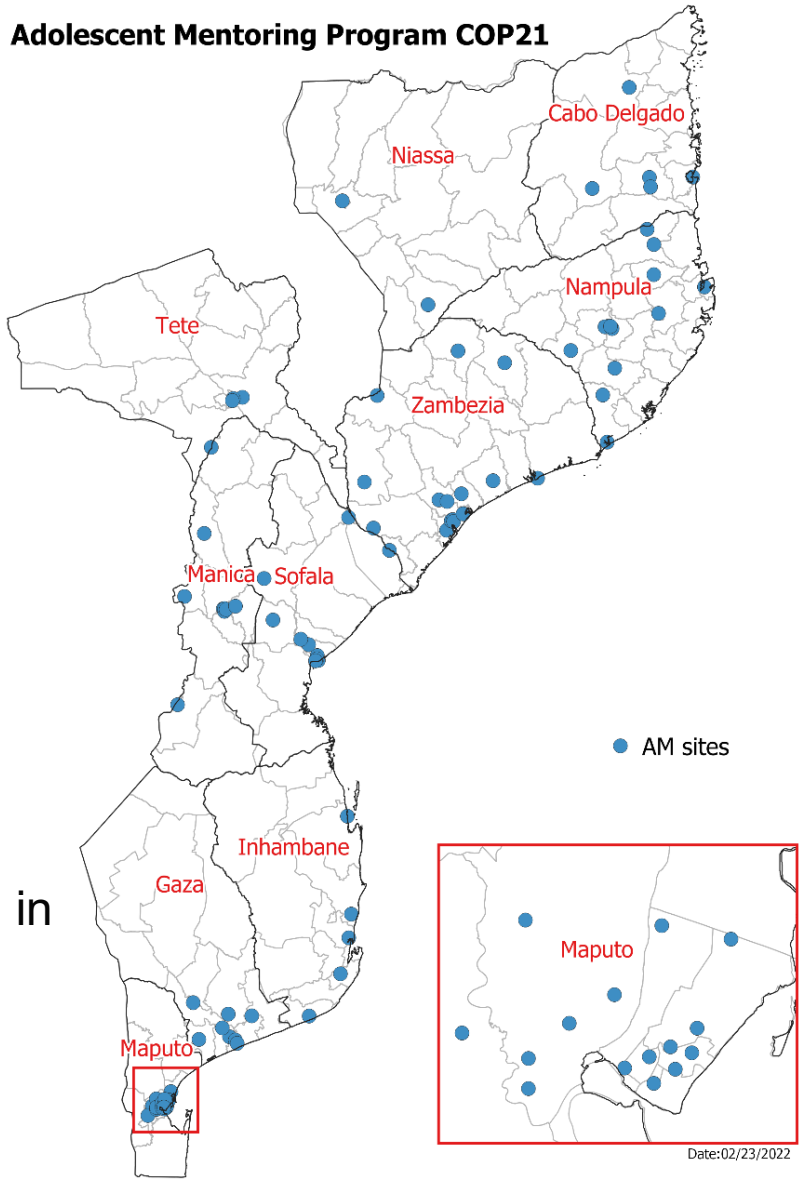
Potential TX_CURR = TX_CURR_prev + TX_NEW

- AHD service scale up in Mozambique with strong focus on children
- Dedicated pediatric central support team supporting new tools, training AHD service sites and providing support to DPS/IPs
- Pediatric clinical mentoring program with strong AHD component

Pediatric AHD consultation room in Maputo City

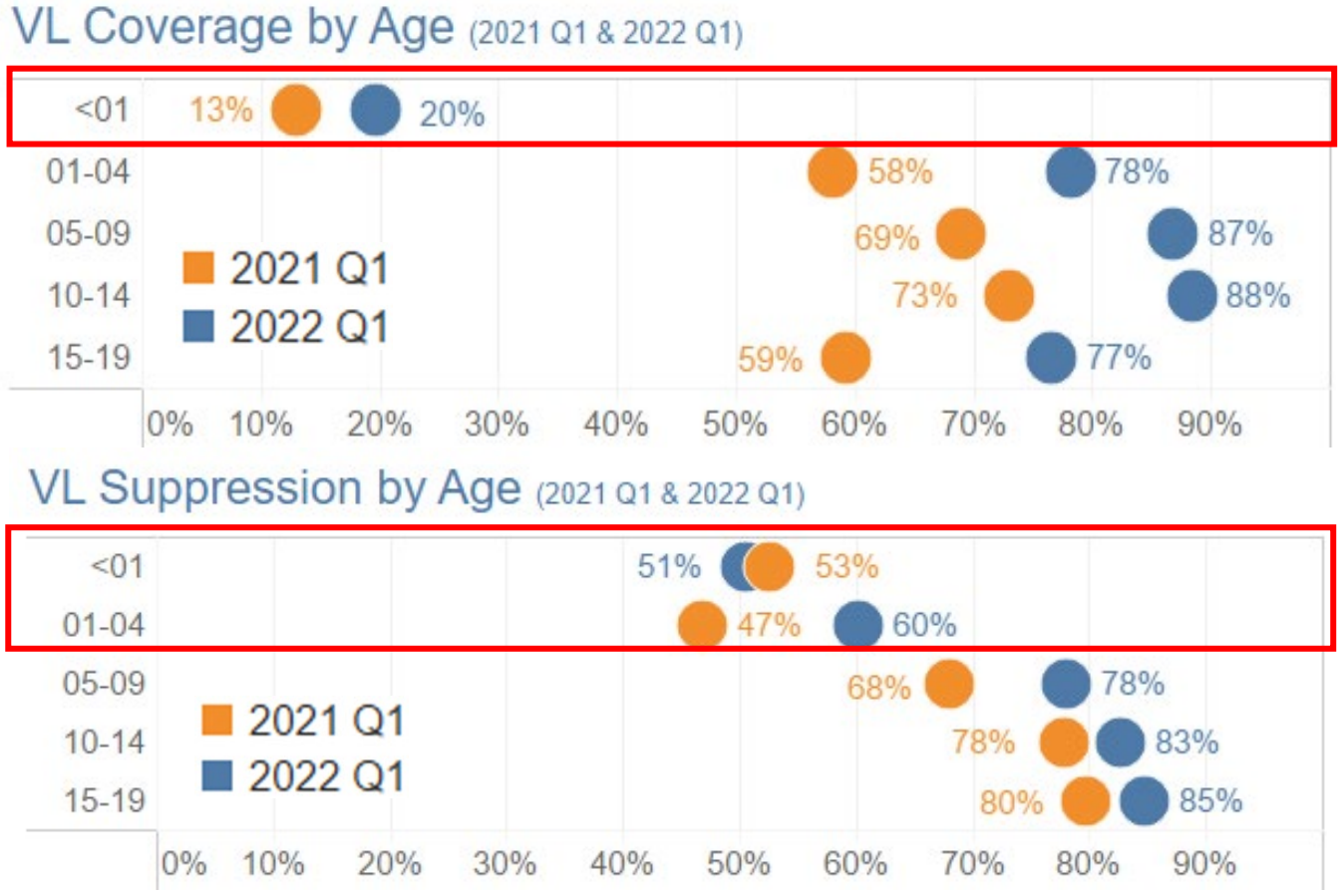
New Cases in AGYW Driving Epidemic – ALHIV Mentors Part of the Solution

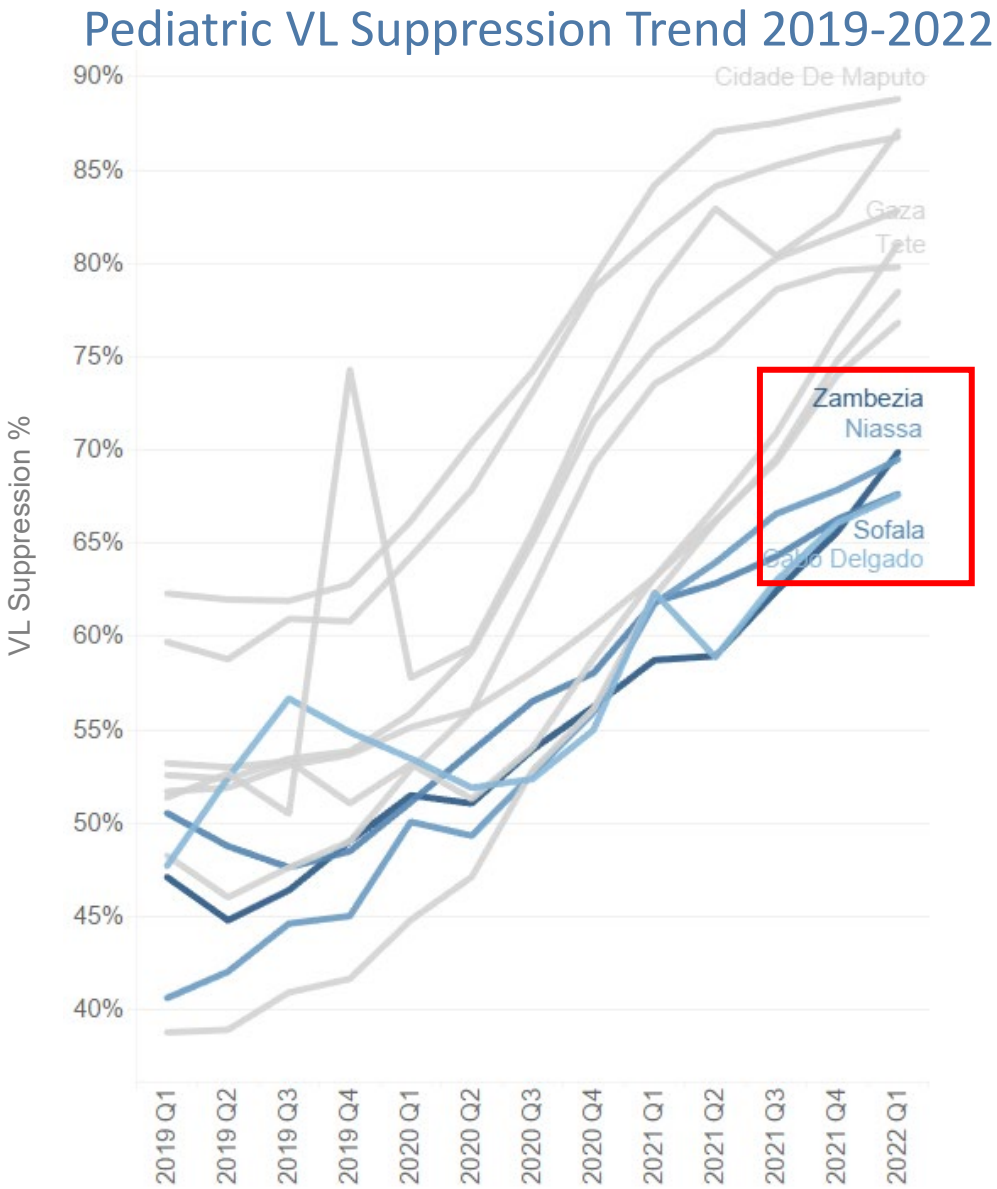




- AM is a peer-based strategy to support prevention of new infections, case identification, adherence and retention among adolescents and young people
- Launch of adolescent mentoring pilot at 22 sites with scale to 90 sites planned in COP21
- Expansion to a minimum of 25 additional sites in COP22 planned
- Male Champion strategy complementary to prevent new AGYW infections

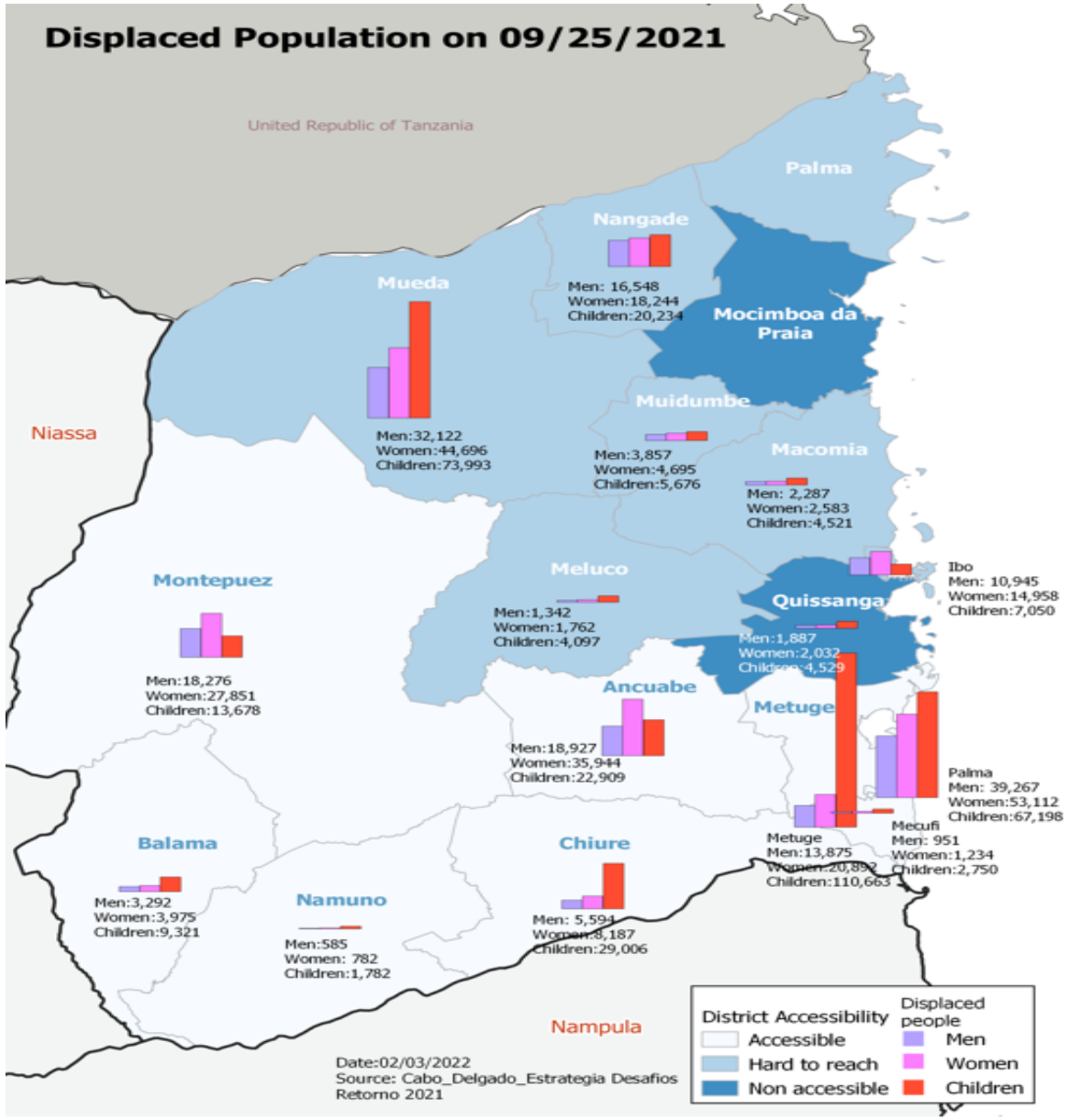
Ongoing Improvements in VLC and VLS for CLHIV, but Youngest Children and Adolescents Lagging in AJUDA sites





- Suppression rates improving but lag for children <5 years
- Challenges remain in northern and central provinces (Cabo Delgado, Zambezia, Sofala, Niassa)

Focused Support for Displaced Children in Cabo Delgado and Nampula

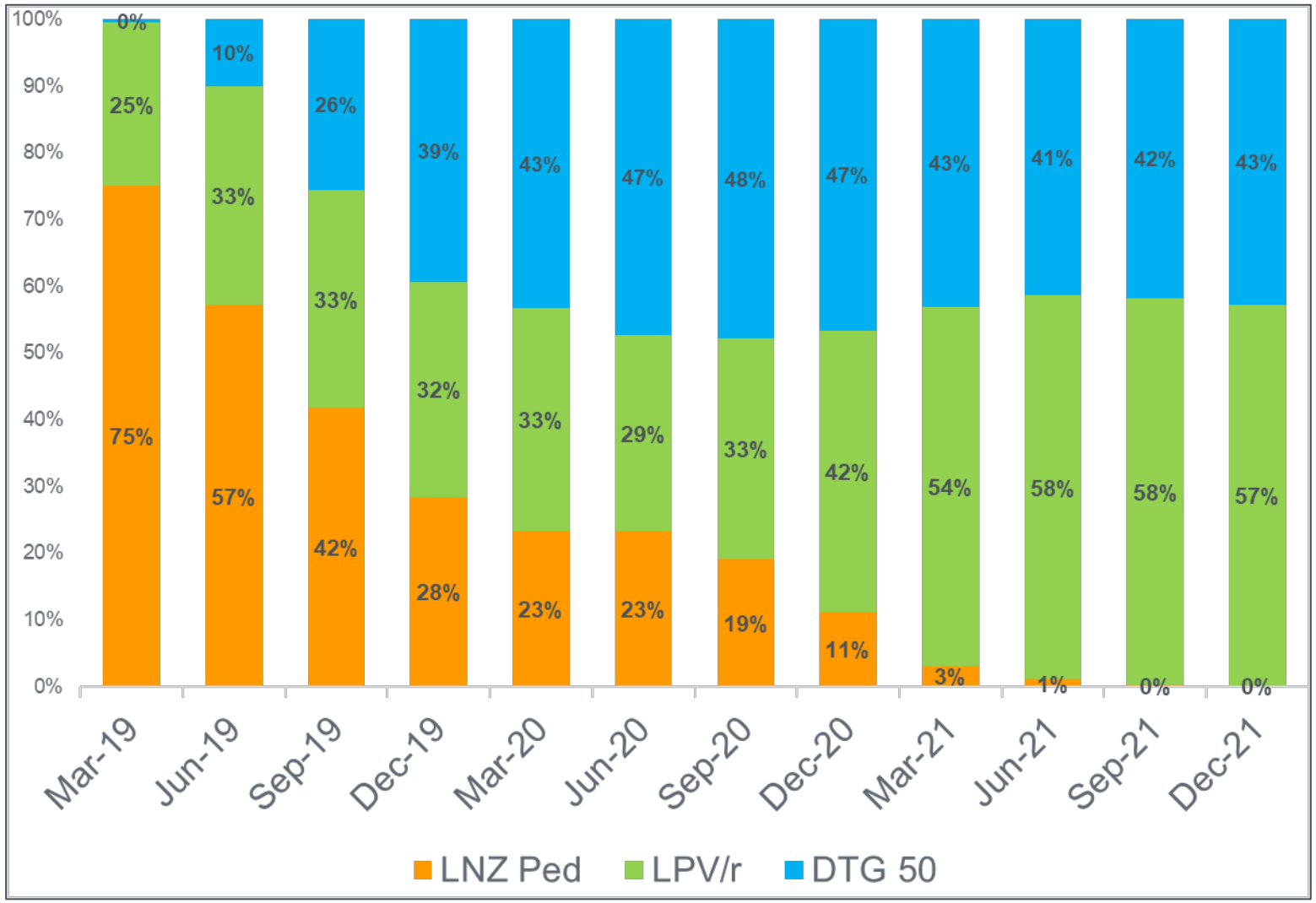


- Ongoing conflict in CDG since 2017 has resulted in the closing of 39 HF (with MCH services and maternities) and 884 HCW affected by the conflict
- PEPFAR reinforcing integrated mobile brigades to IDP communities with pediatric services
- IDP focused mentor mother teams for CLHIV <10 serving resettlement communities in Cabo Delgado and Nampula
- Ensuring synergies with non-PEPFAR donors
- IDP communities prioritized in OVC pivot

Half of IDPs are children

Ongoing Gains in Pediatric ART Optimization for CLHIV < 15 yo

Pediatric ARV Consumptions Trends, March 2019 – December 2021

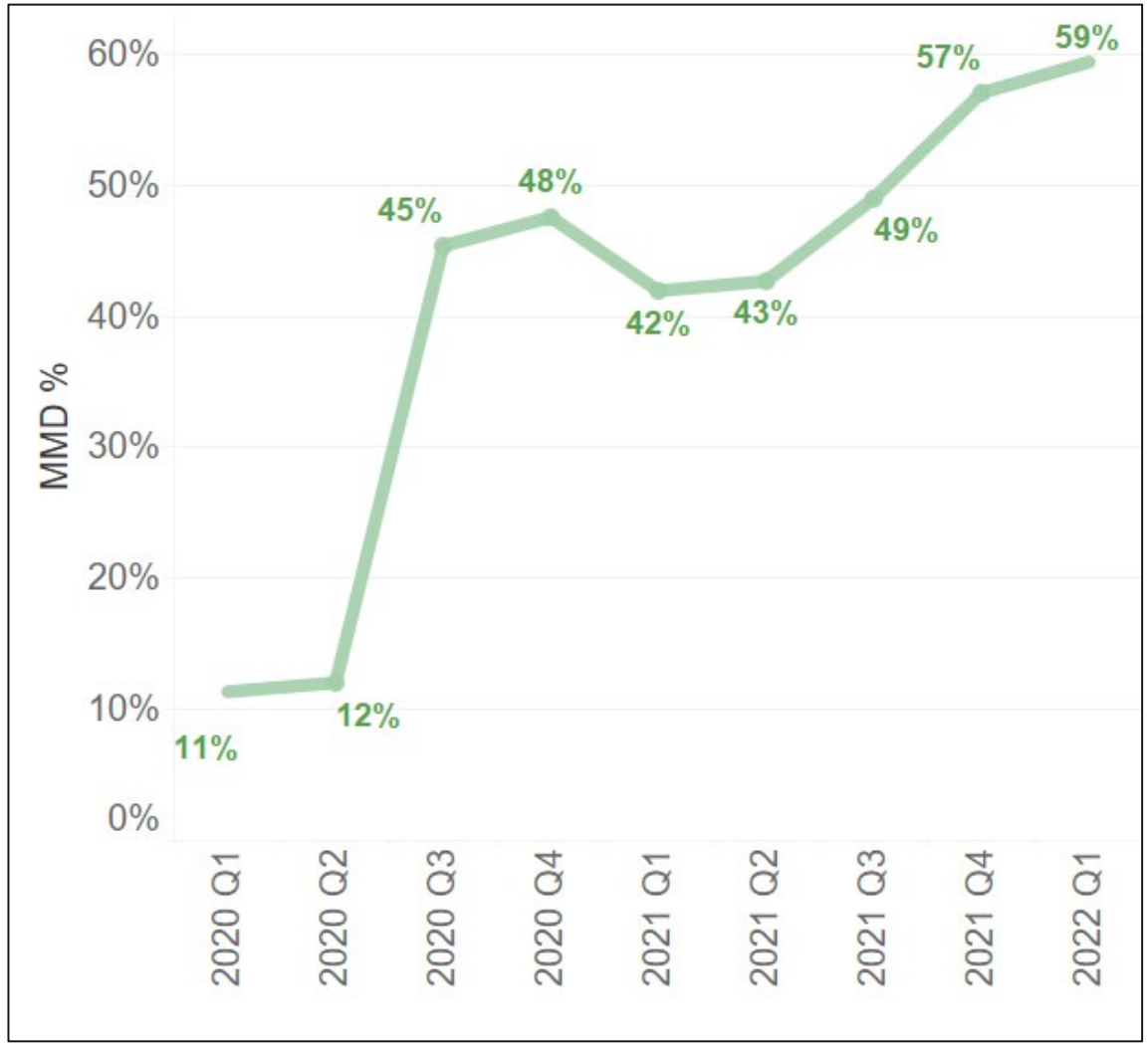


- NVP consumption eliminated
- DTG 50 mg and LPV/r formulations with 43% and 57% consumption among children respectively
- pDTG in-country; dispensing began in February 2022 following training cascade, tool development and supply chain roll out

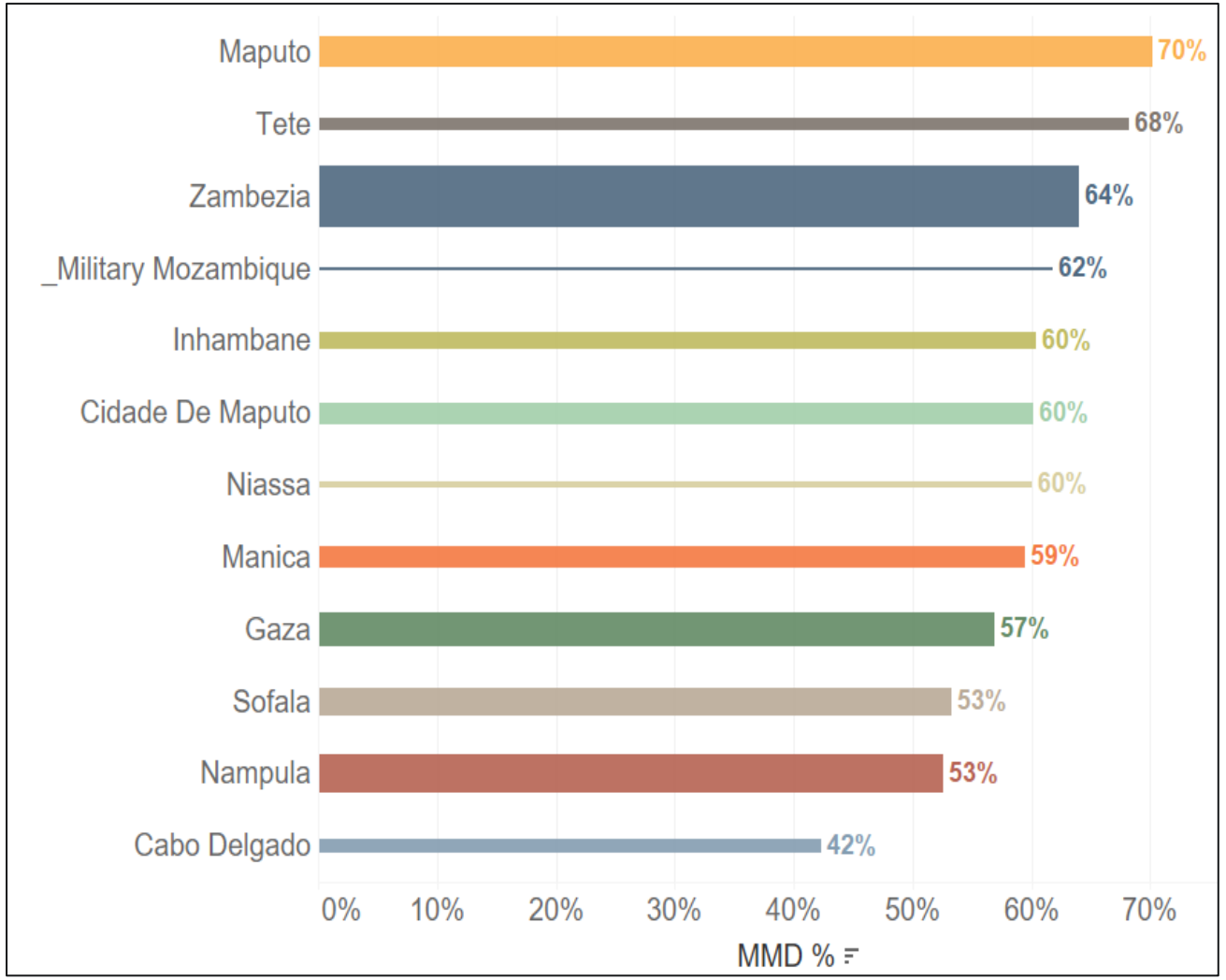
pDTG, when implemented effectively, can rapidly accelerate VLS among youngest children

Ongoing Increase in 3MMD for Children <15 yo (AJUDA Sites) in Q1 FY22

TX_MMD Trend, Children < 15 yo Q1FY 20 to Q1 FY 22



TX_MMD by Province, Children < 15 yo Q1 FY22



How will we accelerate progress?

Blue Sky Initiative, COP22

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Pediatric and PMTCT Surge Planning—Strategic Site Selection

Priority pediatric and PMTCT sites have highest volume gaps

sitename	HEI_POS Not Linked to ART <12 months	PMTCT_EID %	PMTCT_HEI_POS	# Children W/O VL Test	# Children Not Suppressed	Proposed Intensive Support Peds	Proposed Intensive Support PMTCT
Eduardo Mondlane C	0	91%	15	113	61	x	x
1° Maio CS	0	99%	14	59	37	x	x
Nhamaonha CS	0	90%	16	67	52	x	x
Manica HD	0	93%	4	42	45	x	x
Gondola Sede CS	0	110%	4	84	59	x	x
7 de Abril CS	0	82%	16	28	67	x	x
Catandica HD	0	102%	7	93	47	x	x
Guro - Sede CS	0	97%	7	56	32	x	x

Pediatric Composite Score

Number of children lacking VL test

Number of children not suppressed

PMTCT Composite Score

Number of HIV infected infants

Number of HIV infected infants not linked to care

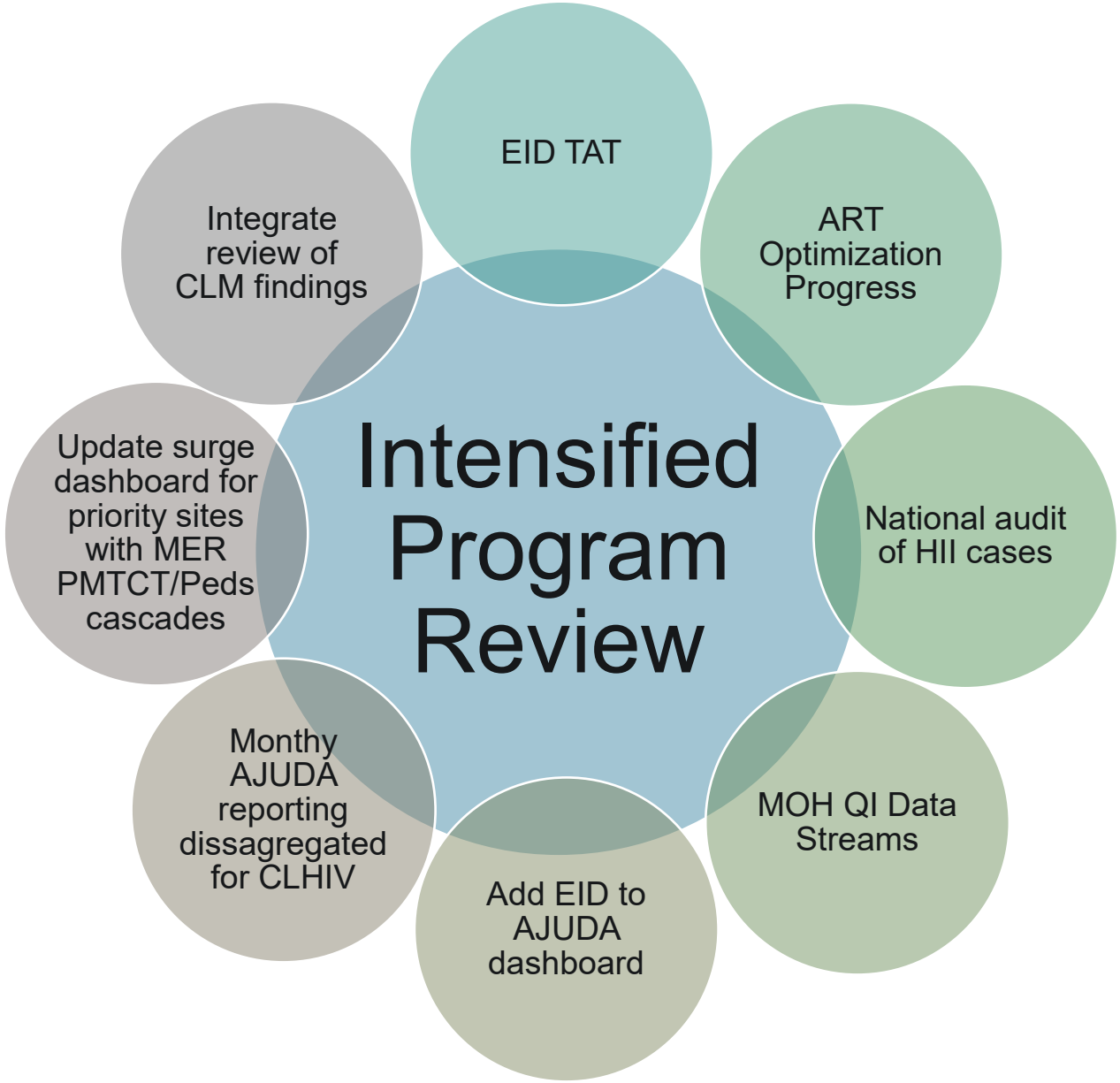
EID Testing Coverage

131 Priority Pediatric Sites, serving >40% CLHIV in each province

82 of these sites are priorities for both programs

138 priority PMTCT sites, serving >40% HII in each province

Intensified TA and Program Review by Partner and PEPFAR Teams



Site Visits to Priority Sites Framing and Driving Change

Integration within national QI program

MoH/PEPFAR joint site visits: Identify specific challenges, provide TA, create targeted solutions, support site level QI plans

Performance review: tracked through monthly AJUDA data; Surge dashboard for selected sites.

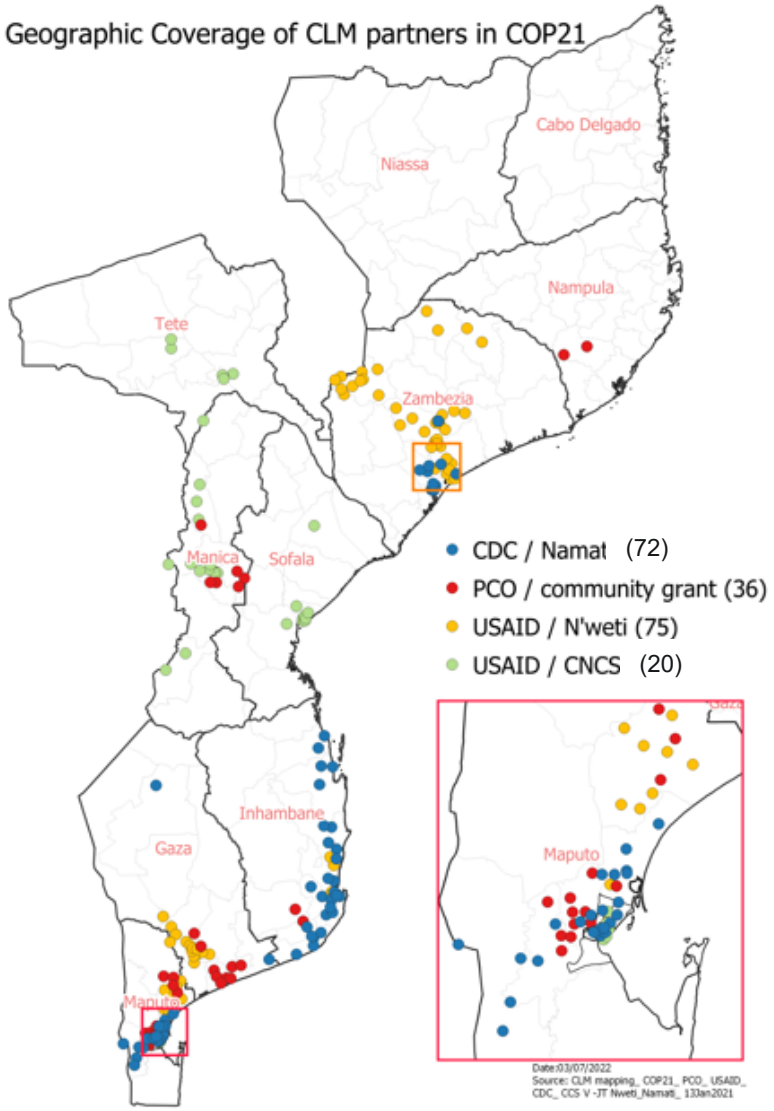
Adjust partner implementation: Site level realities drive provincial shifts in resources and strategies

Provincial and central findings and data review meetings

Enhanced Clinical Mentoring for Pediatric/PMTCT Services

Challenges with current PMTCT/ Peds mentoring model	• Uneven quality in clinical care • Inconsistent implementation (fidelity) of MCH/PMTCT integrated mentoring package • High turnover and workload of mentors • Uneven technical capacity of mentors • High turnover of mentees
Proposed intensified PMTCT and Peds monitoring platform	• Intensify implementation of existing package • Mobile provincial TA team supported by IP complementary to MOH mentoring team • Experienced professionals in provision of MCH/PMTCT, pediatric care and PSS support • 1-2 week site visits with intensive mentoring to reach standard of care
Improved management and coordination	• Strong coordination between IP mentoring team and DPS/SPS • Use of MoH mentoring tools and guidelines • Ensure stability of mentored providers at HFs (reduced attrition/absenteeism) • Provincial advisors placed in DPS with MISAU salaries (MOH priority) • Reinforce site level QI plans
Support site team to implement best practices	• Identification of consultation rooms for peds, preferably as one-stop-shop model with family approach • Ensuring team approach with mentor mother/counselor/psychologist/clinician/pharmacist • Supporting routine case and data review • Scaling critical interventions rapidly (ART optimization, DSD models)

Communities Leading Change in the Care of Women and Children



- Four mechanisms currently support CLM in 203 sites, including 55% of PMTCT/PEDs Blue Sky priority sites
- Community assessments driven by community/patient priorities
- ART services for children, youth friendly services (SAAJ) and MCH services (ANC, post-partum, family planning, maternity) among the services assessed
- CLM with focus on resolution of grievances and practical changes at health facility level
- Grievances frequently raise health worker behavior (lack of information regarding patients' health, absenteeism and disrespect)
- CLM can bring deeper benefits to MCH sub-populations:
  - Discussions focused on MCH sectors ground truth services for children and PLW
  - Blue Sky surge to include review of site level grievances and resolution strategies in priority sites

DSD Staffing Essential for MCH Surge Success

This tab should summarize the site-level HRH on the "Site Detail" tab

Partner	Province	Cadre Name	PEPFAR Estimated Need (Starting point for discussion, not a mandate)	Total # Proposed by Partner in COP20	Total Estimated Salary and Fringe of All Members of this Cadre in COP20	Total # Proposed by Partner in COP21	Government Cadre Name	Annual Full-Time Starting Government Salary	Full-time vs. Part-time
ICAP	Nampula	Doctor		0	$ -	0			
ICAP	Nampula	Other MCH Nurse		23	$ 69,000	24	Enfermeira de SMI	3000	All staff are full-time
ICAP	Nampula	Other Clinical Officers, e.g. Tecnico de Medicina		42	$ 126,000	51	Tecnico de Medicina Geral	3000	All staff are full-time
ICAP	Nampula	CECAP Nurse		23	$ 69,000	30	Enfermeiro Geral	3000	All staff are full-time
ICAP	Nampula	Other Pharmacy Tech		0	$ -	0	Tecnico de Farmacia		
ICAP	Nampula	Other Lab Tech		47	$ 141,000	44	Tecnico de Laboratorio	3000	All staff are full-time
ICAP	Nampula	Motorbike Drivers - Lab				0			All staff are full-time
ICAP	Nampula	Other Lay Counselor (APSS)		143	$ 279,708	198	Conselheiro Leigo	1956	All staff are full-time
ICAP	Nampula	Other Lay Counselor (HTC)		111	$ 217,116	169	Conselheiro Leigo	1956	All staff are full-time
ICAP	Nampula	Mentor Mother (facility)		44	$ 43,824	170	Mae Mentora	996	All staff are full-time
ICAP	Nampula	Mentor Mother (community)		78	$ 108,576	126	Mae Mentora	1392	
ICAP	Nampula	Adolescent (age 15-19) peer educator (facility)		61	$ 60,756	18		996	
ICAP	Nampula	Adolescent (age 15-19) peer educator (community)		0	$ -	47		996	
ICAP	Nampula	Young adult (age 20-29) case manager (facility)		30	$ -	94			All staff are full-time
ICAP	Nampula	Young adult (age 20-29) case manager (community)		0	$ -	0			
ICAP	Nampula	Cough Officer		63	$ 87,696	63		1392	All staff are full-time

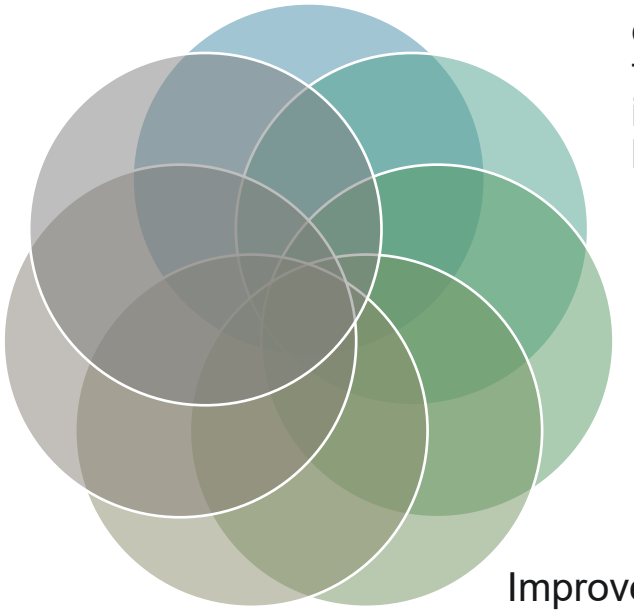
- HRH estimates that $1,074,032 in addition to maintenance of COP21 HRH investment would be needed to close HRH gaps in Blue Sky priority health facilities
- Provinces with the largest staffing gaps are Zambezia, Maputo City, Gaza and Manica
- The current budget maximizes strategic efficiencies with site level funding priorities at the forefront
- Program growth and rising commodity costs require trade-offs

Mentor Mothers Remain a Critical Support to PLW/CLHIV in COP 22

Site level implementation at 598 (95%) AJUDA sites in Q1

Continue funding M2M in CDG, Nampula and Zambezia given superior results

Continued push to scale coverage during COP21; aim to maintain footprint in COP22, despite budget pressure

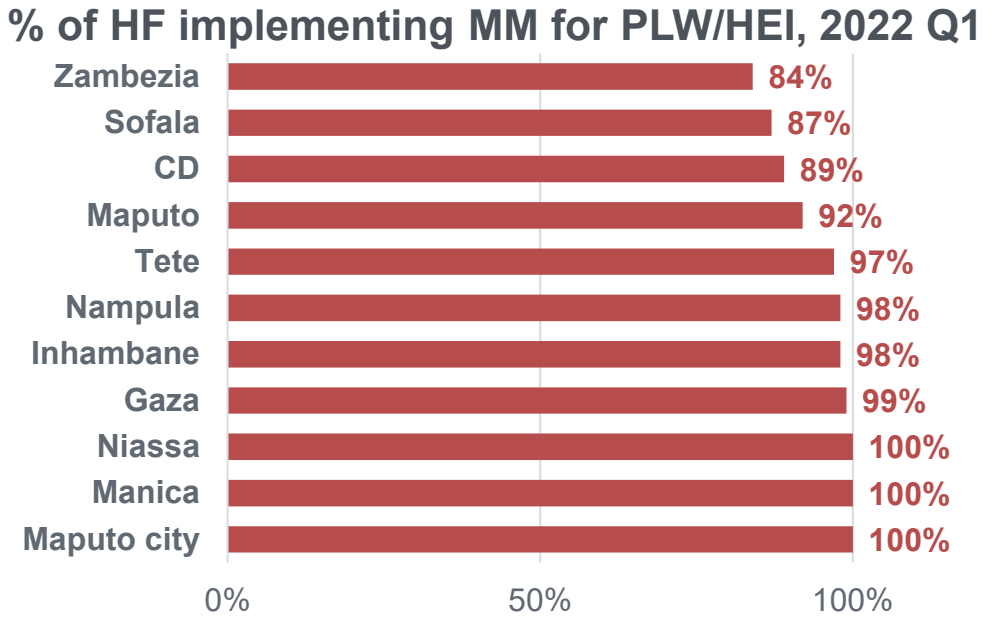


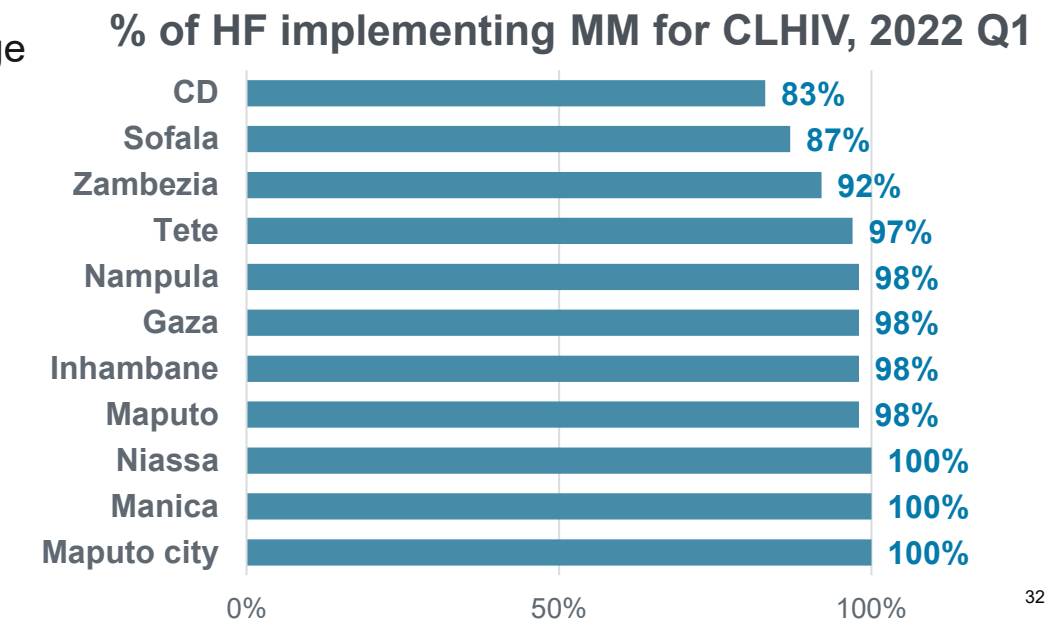
Tailored support to PLW and CLHIV in emergency settings via IDP focused MM teams in Nampula and CDG

Ensure 100% PLW and CLHIV coverage for all consenting patients in AJUDA sites

Introduction of quality standards for MM services

Improve fidelity of implementation (mentorship/training/supervision, focus on low performing facilities)





Maximize PMTCT and Pediatric Programming Impact

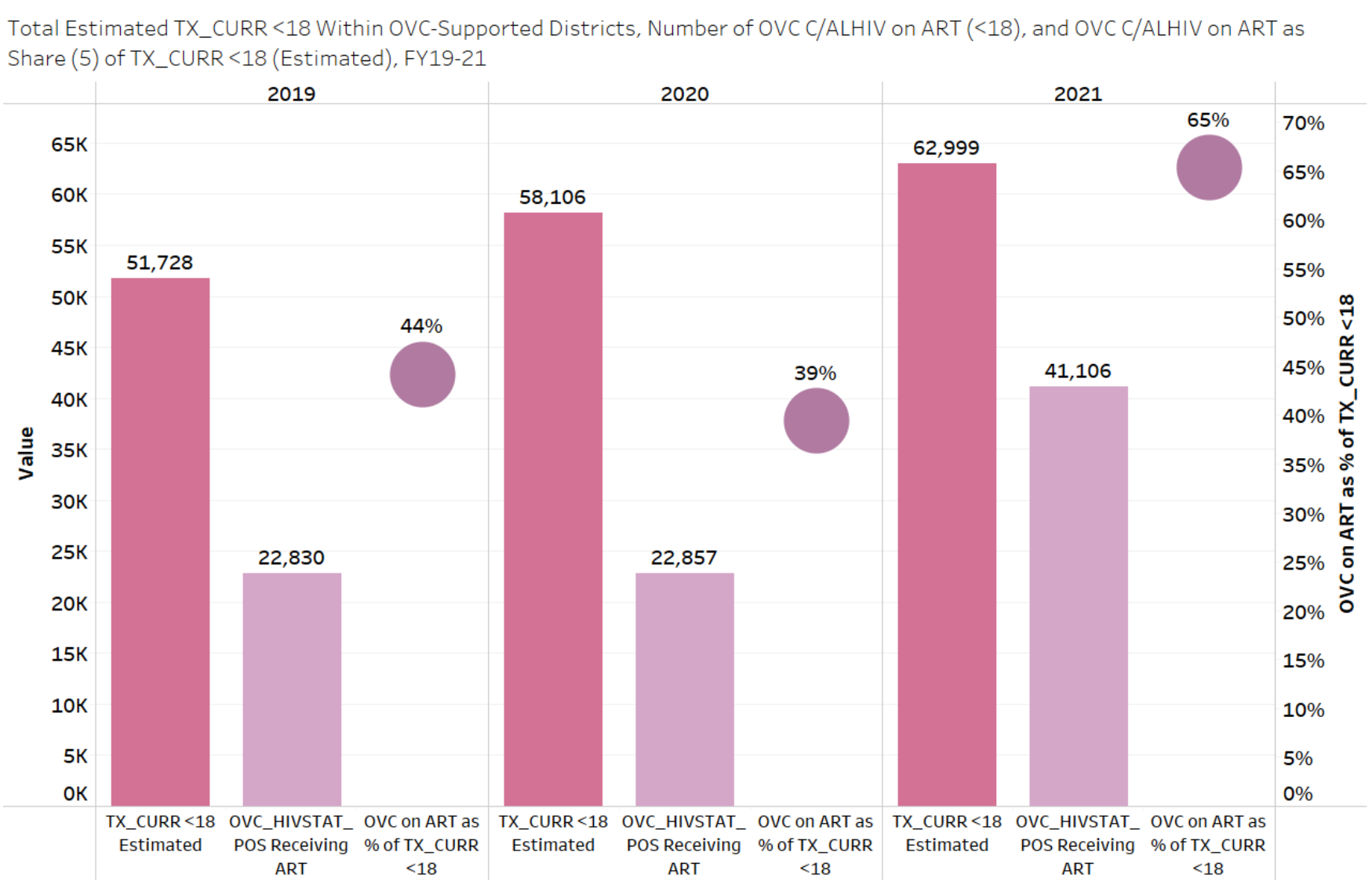
- Surge approach at priority sites supported by IP, MISAU and PEPFAR teams, aligned with national MISAU QI initiative
- Support pDTG roll-out for rapid gains in pediatric VLS
- PMTCT and pediatric clinical mentoring initiative
- HRH clinical services top-up to priority sites
- Adolescent mentoring expansion
- Mentor mother budget protected with top-up to fully scale support to CLHIV <10
- IDP programming for MCH sub-populations
- Improved ICT implementation for children
- **FOCUS ON QUALITY IN IMPLEMENTATION**
- **PATIENT CENTERED CARE**

Mentor mother at work, Pedreira HF, Zambezia

OVC Program in COP22

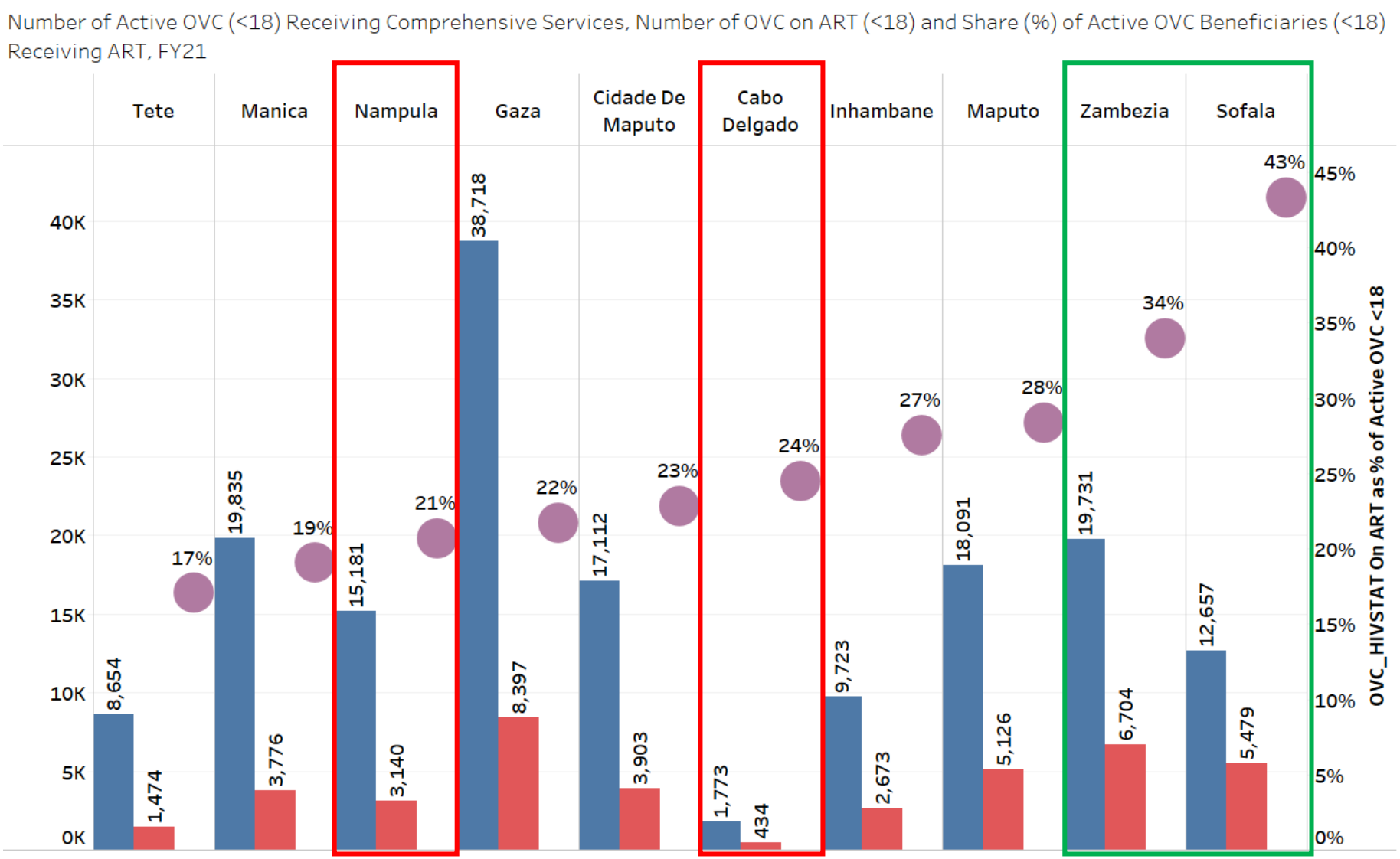
OVC Geographic Alignment, Optimization, & Programmatic Shifts to Support to C/ALHIV, Mothers of HEI, & IDP

65% Estimated Coverage of C/ALHIV on ART Within OVC Program Districts



- **80% increase in C/ALHIV on ART** enrolled in OVC Case Management during FY21
- **65% estimated district-level coverage** of C/ALHIV on ART within OVC program districts
- **42% estimated national-level coverage** of C/ALHIV on ART; limited by OVC program geographic footprint
- OVC program must continue to expand to keep pace with growth in pediatric ART enrollment

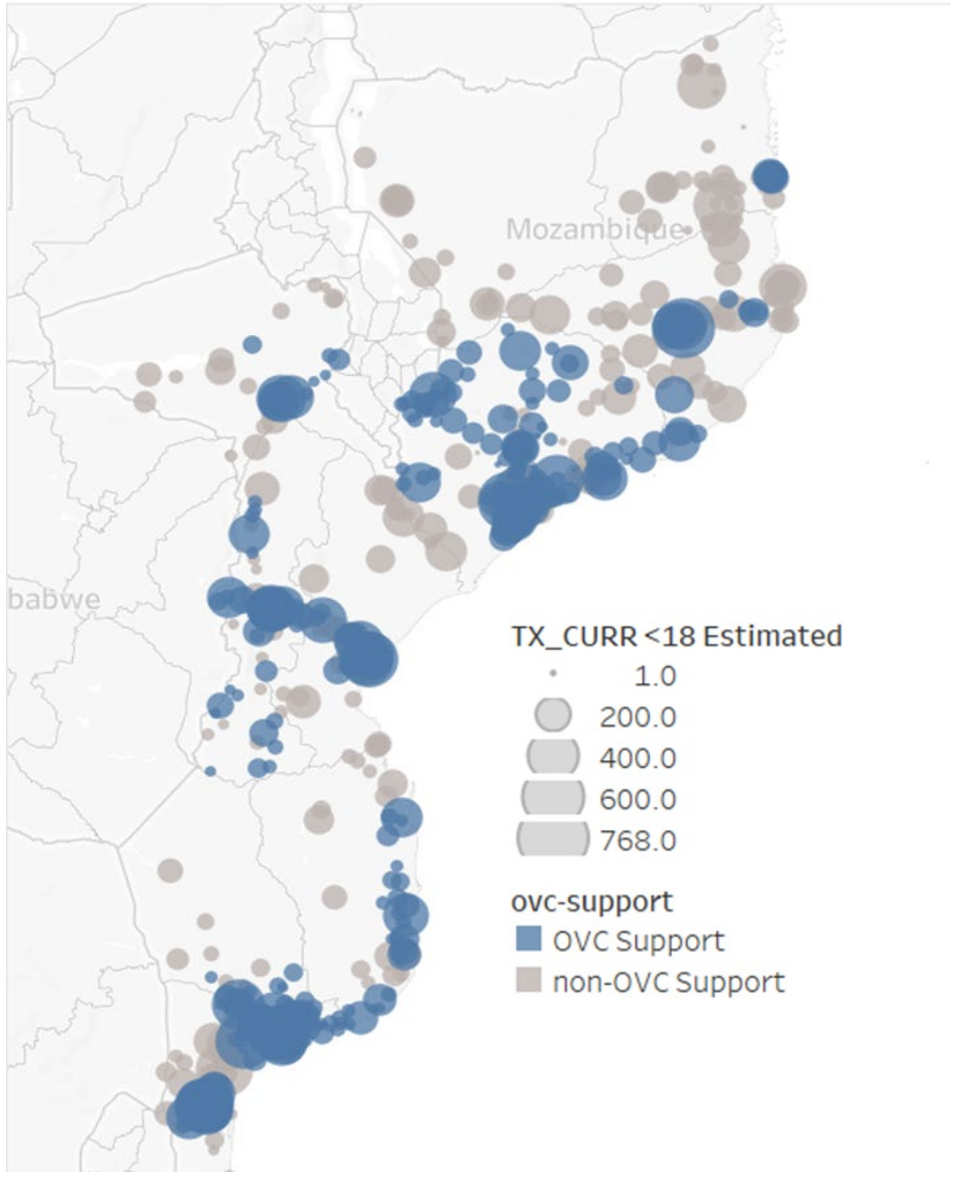
C/ALHIV on ART Now 25% of Active OVC <18 in Comprehensive Services



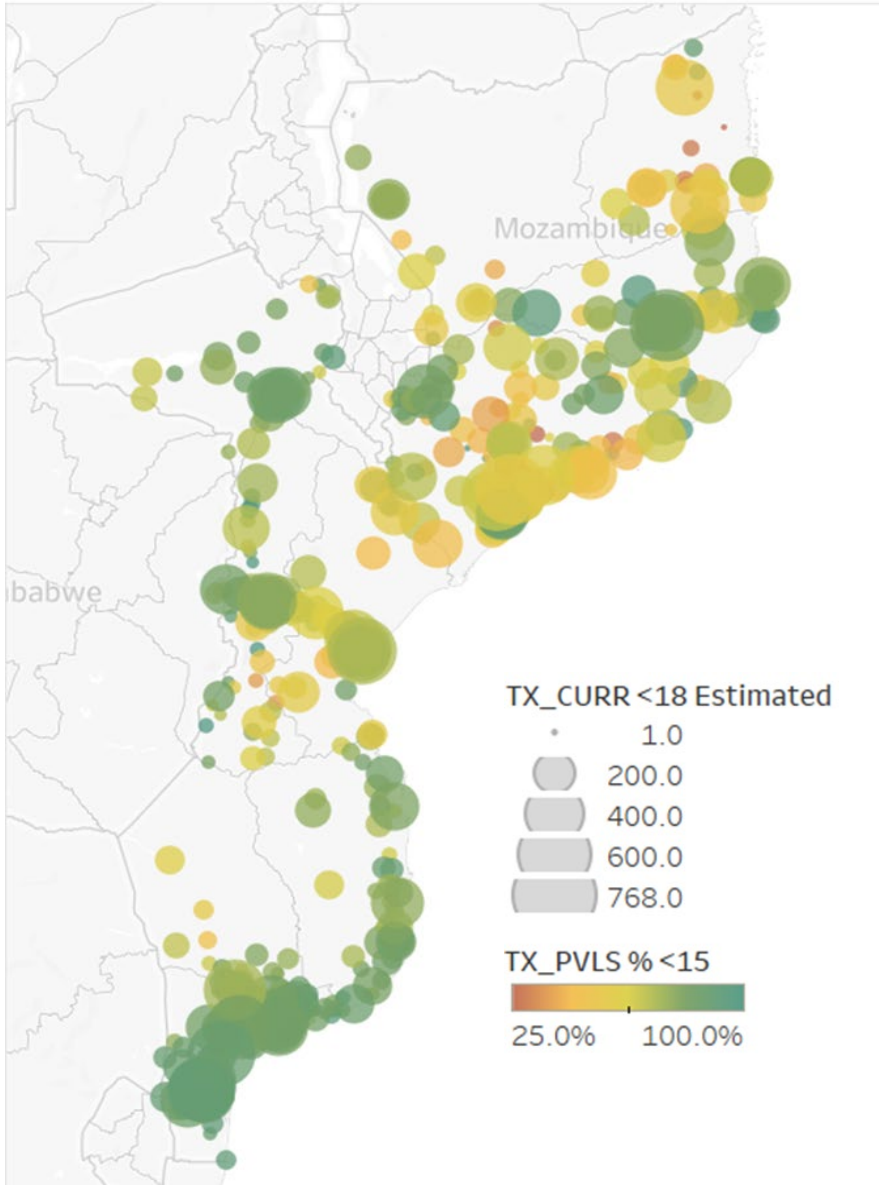
- Shift in OVC program has led to greater share of C/ALHIV on ART actively receiving OVC comprehensive services
- C/ALHIV on ART occupy greater share of actively case-managed OVC within highest-burden SNUs (e.g. Sofala & Zambezia),
- Nonetheless, need to consider geographic shifts to enable greater numbers of OVC enrolled in case management in other high-burden SNUs

Need to Align OVC Case Management With Geography of Need

OVC Site-Level Presence, by C/ALHIV on ART (<18), FY22 Q1.

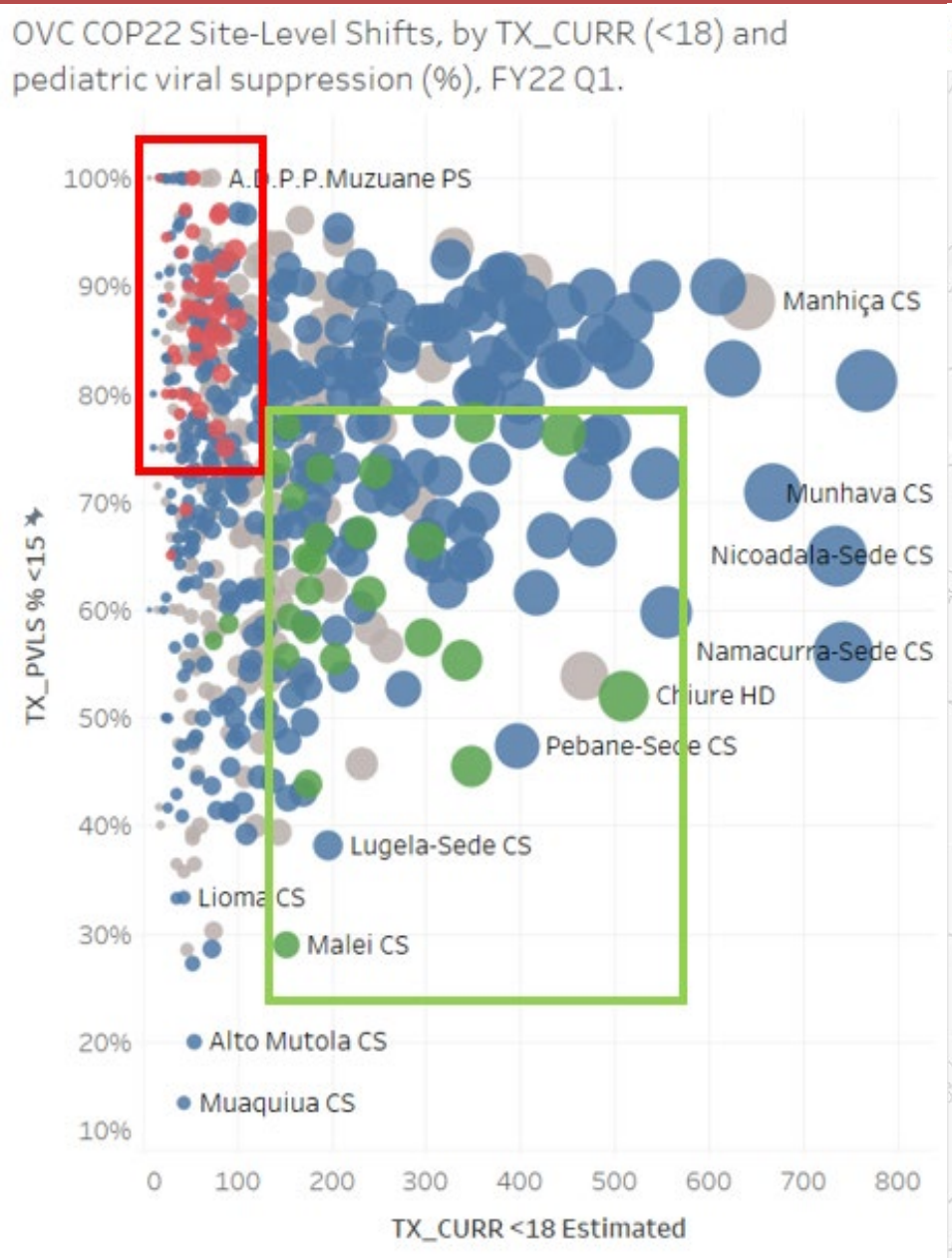


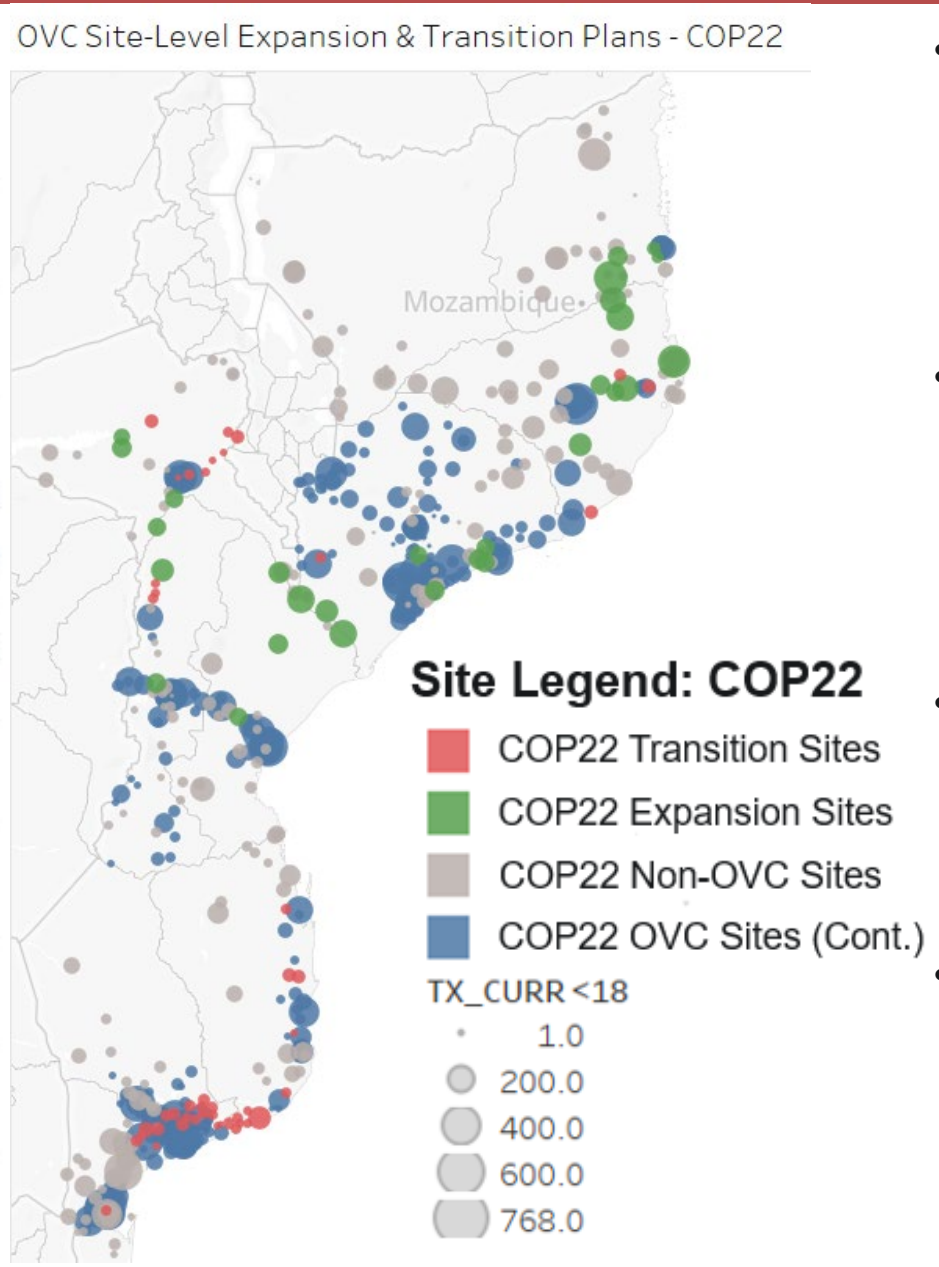
Site-Level Pediatric Viral Suppression; All Sites, FY22 Q1



- Current OVC district-level presence established in COP19, **aligned with pediatric HIV burden**
- Site-level support clustered within OVC program districts
- Several sites with **large numbers of C/ALHIV on ART** and **low pediatric viral suppression,** not currently covered by OVC program.
- Limited OVC program presence in northern Provinces (Cabo Delgado, Nampula), which now report the lowest pediatric viral suppression rates, and have large IDP populations.

OVC Site-Level Optimization to Support Higher-Volume Sites with Low VLS





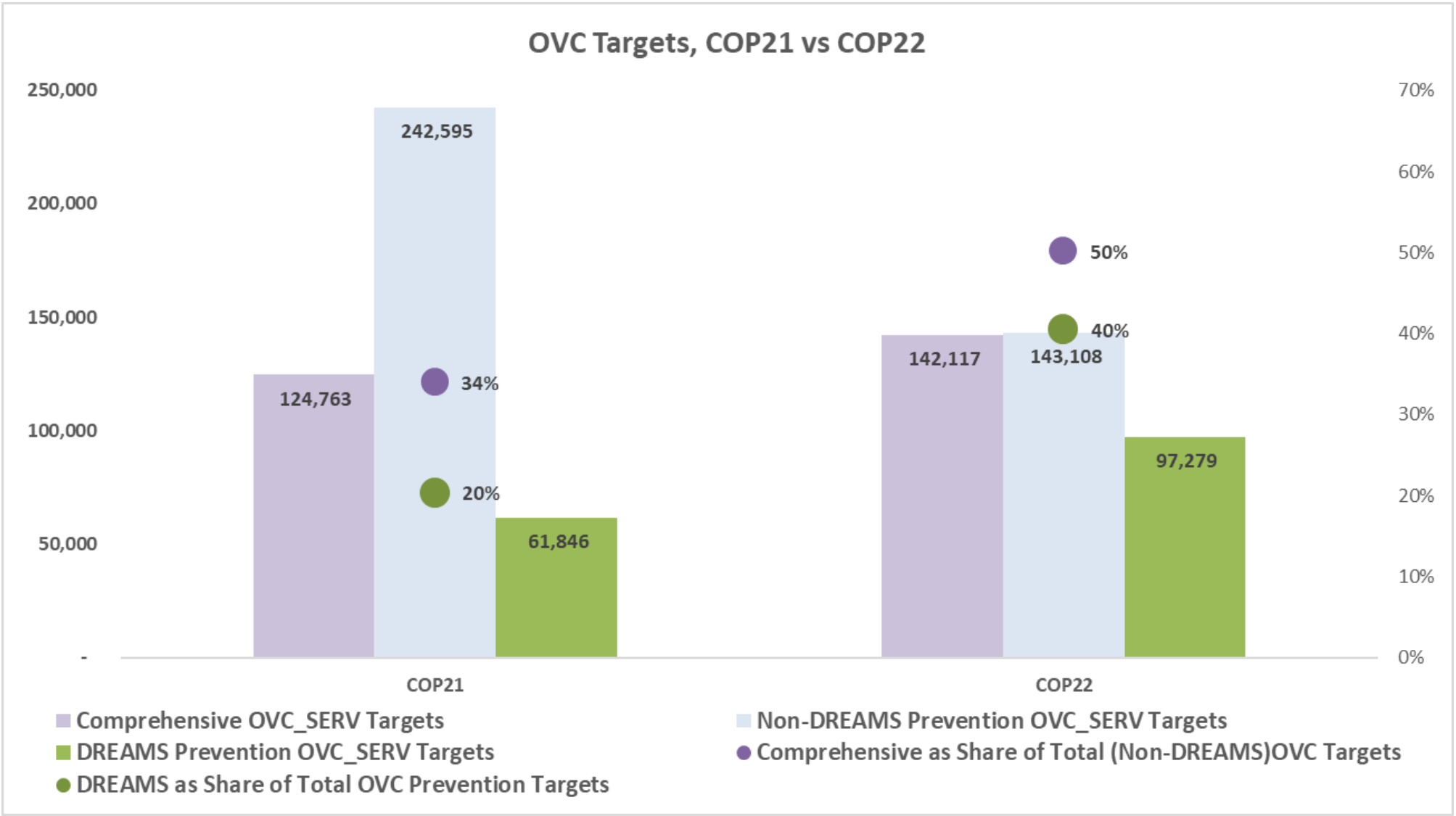
- **Prioritized expansion into 29 high-volume sites** with 150+ C/ALHIV on ART and **VLS% or VLC% below 75%** for expansion.
- **Aligned expansion plans with IDP** population size estimates & geographic feasibility, in coordination with Inter-Agency MCH teams.
- **Identified 49 stable, low volume sites** with VLS% and VLC% above 75% for gradual transition during COP21.
- **Will ensure clear hand-over plans for each OVC beneficiary** at transition sites; will only exit once all are stable & graduated.

Targeted Increases in OVC Comprehensive Case Management

Province	COP21 Total Comprehensive OVC_SERV Targets	COP22 Pediatric TX_CURR Targets	COP22 Total Comprehensive OVC_SERV Targets	FY22 Q1 Pediatric Viral Suppression %	COP22 % Change in Comprehensive OVC_SERV Targets Over COP21
Cabo Delgado	2,222	4,552	7,436	60%	235%
Zambezia	34,574	21,289	39,847	60%	15%
Sofala	14,401	9,926	15,713	64%	9%
Nampula	9,286	12,122	15,750	72%	70%
Manica	11,666	7,553	13,234	72%	13%
Tete	5,306	5,102	5,265	73%	-1%
Inhambane	4,930	5,691	5,612	79%	14%
Gaza	18,384	10,348	16,658	80%	-9%
Maputo	12,712	8,982	11,874	85%	-7%
Cidade De Maputo	11,282	7,047	10,728	88%	-5%
Grand Total	**124,763**	**92,612**	**142,117**		**14%**

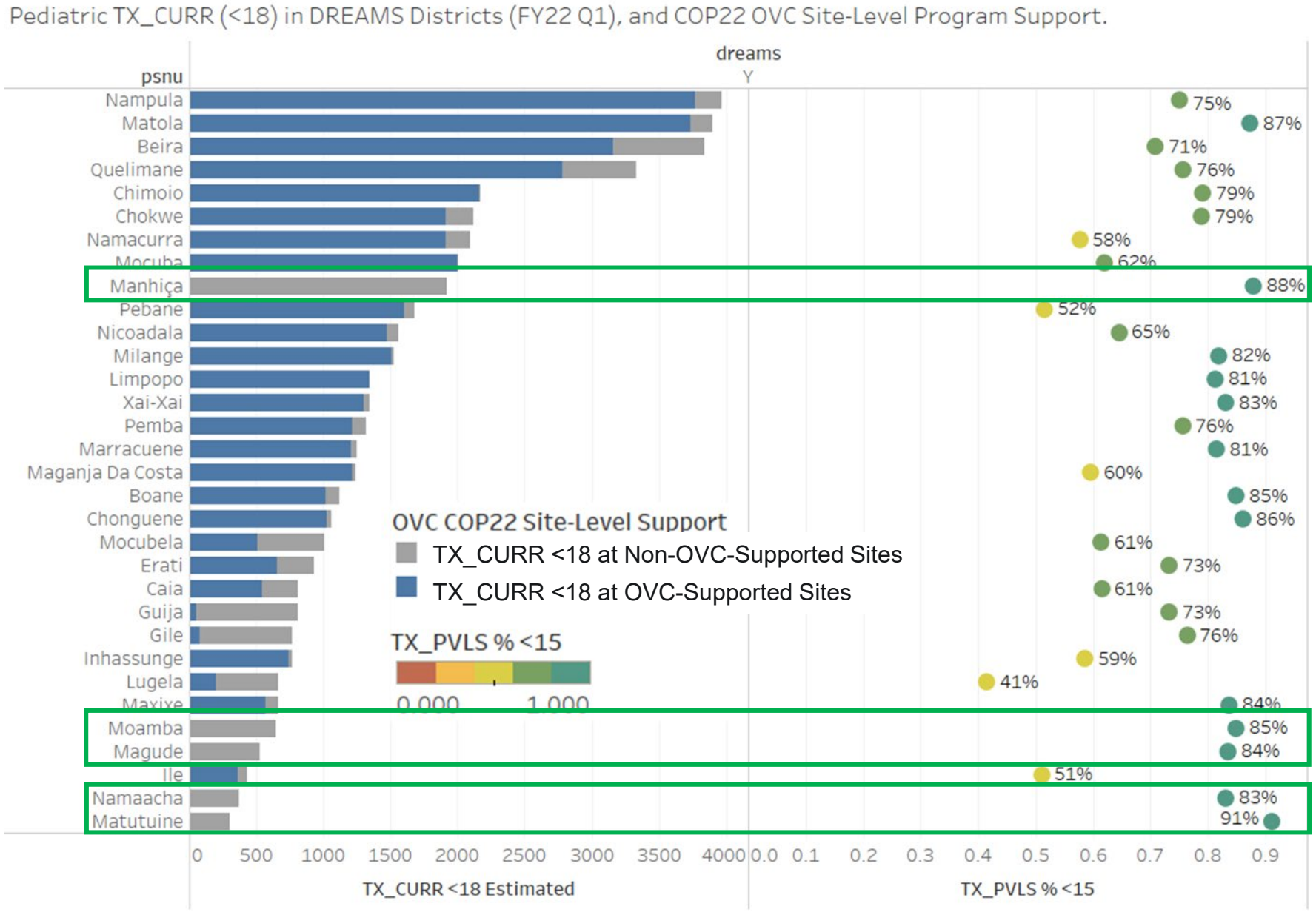
- Overall **14% increase in Comprehensive** Case Management targets in COP22 vs COP21
- Will allow for enrollment of **additional 13,883 C/ALHIV on ART** in COP22, above COP21 targets, with 20 fewer HF to support
- Shift comprehensive targets to **provinces with lower pediatric viral suppression**

Shift to Offer More OVC Comprehensive Case Management



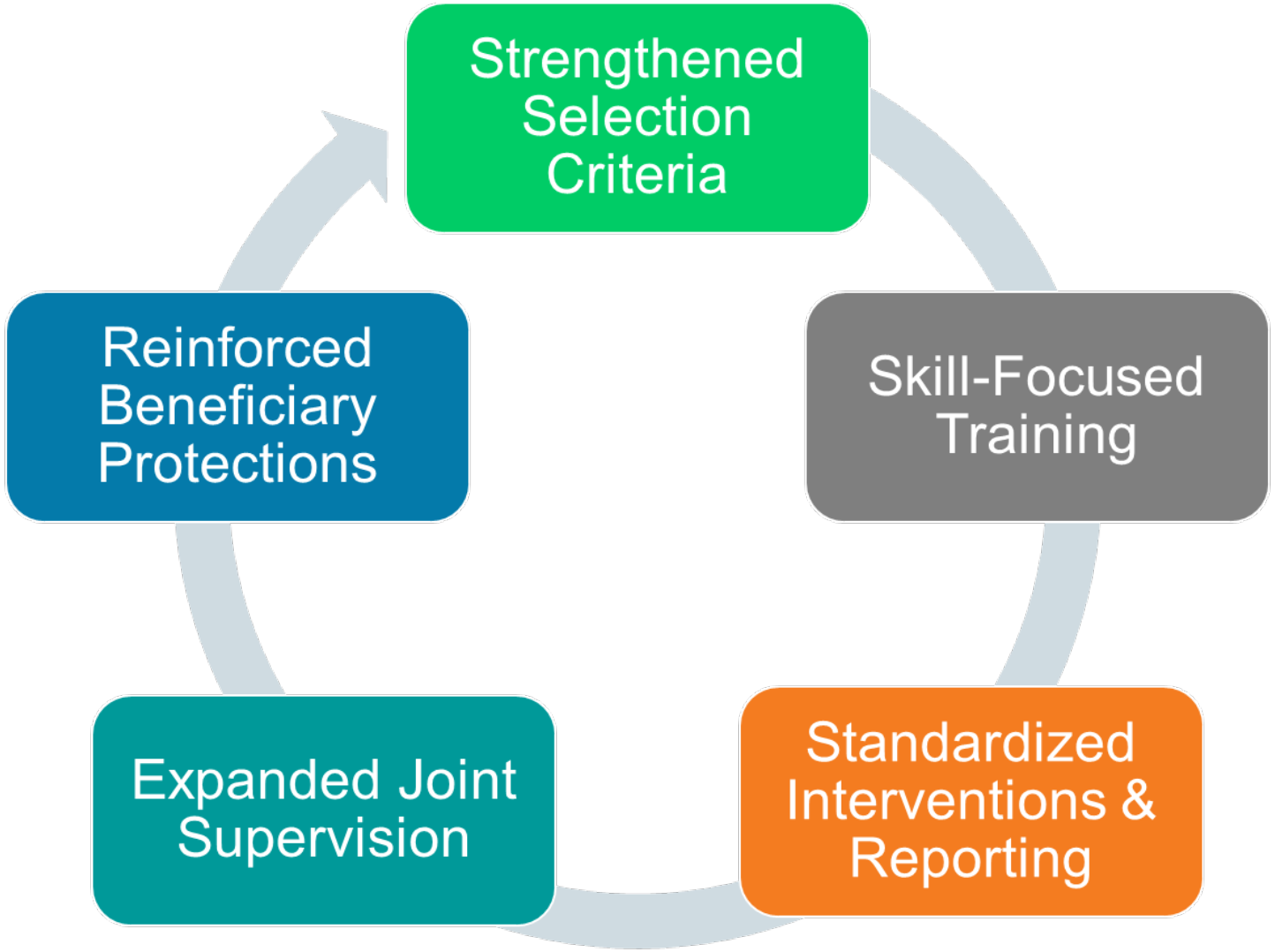
- **21%** reduction in OVC Prevention targets; **41%** reduction in Non-DREAMS Prevention OVC targets
- DREAMS prevention activities with 10-17 year-olds within OVC districts account for **40%** of OVC Prev. targets in COP22
- Increased budgeted comprehensive unit cost per beneficiary per year, from **$69.85** to **$76.61 (all inclusive)**

Strong OVC-DREAMS Overlap & Synergies at the District & Site-Level



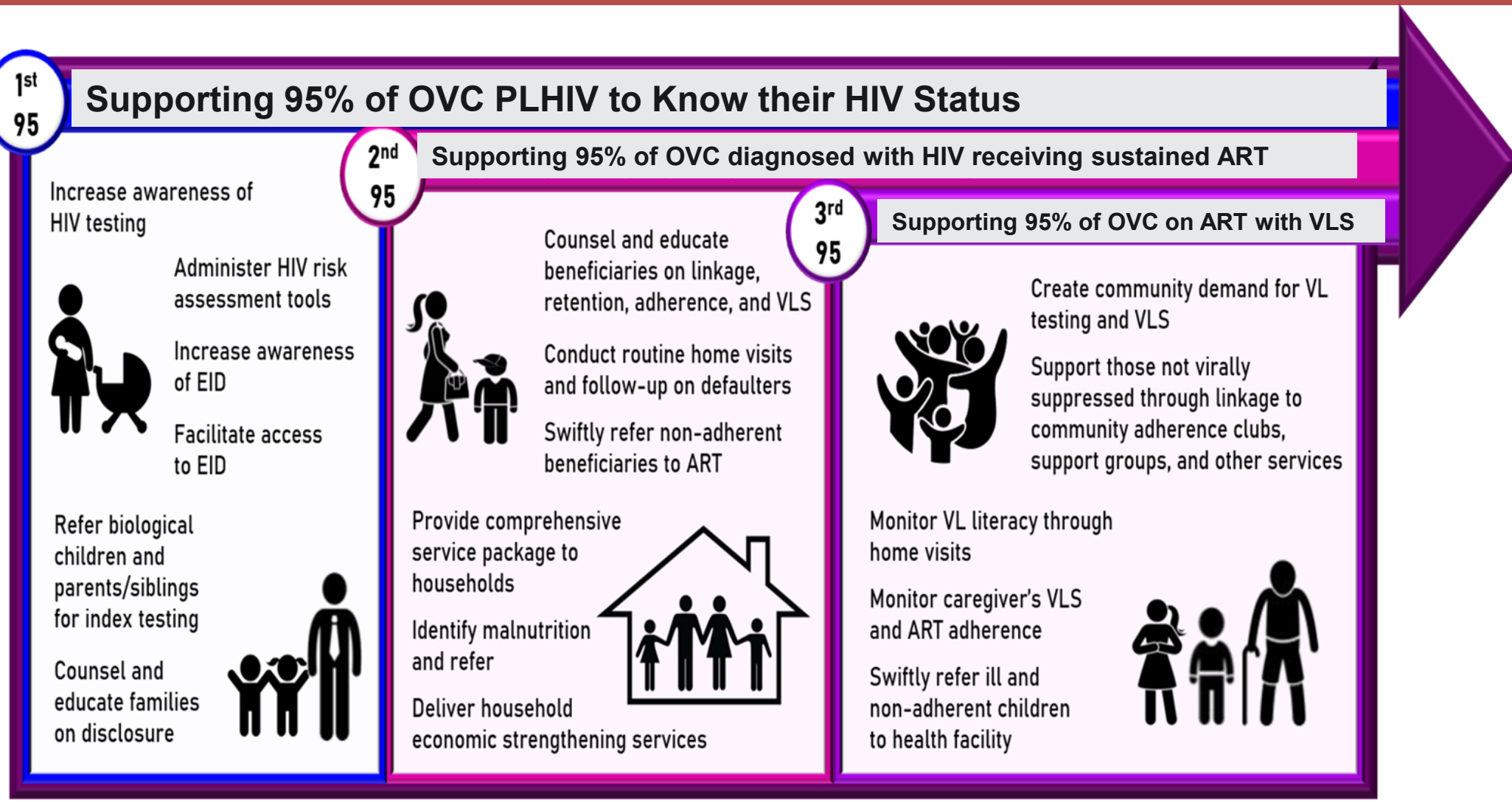
- OVC program is well aligned geographically with the DREAMS program
- OVC program overlap in **27 out of 32 DREAMS** districts for COP22
- Able to enroll **80% of C/ALHIV on ART** in DREAMS districts (collectively)
- 5 DREAMS districts without OVC program presence **(**Manhiça, Moamba, Magude, Namaacha, & Matutuine) have pediatric viral suppression of **83-91%**
- Using same community IPs for both programs in **31/32** districts offers significant synergies & efficiencies

Improving Quality & Standardization of OVC Case Management in COP22



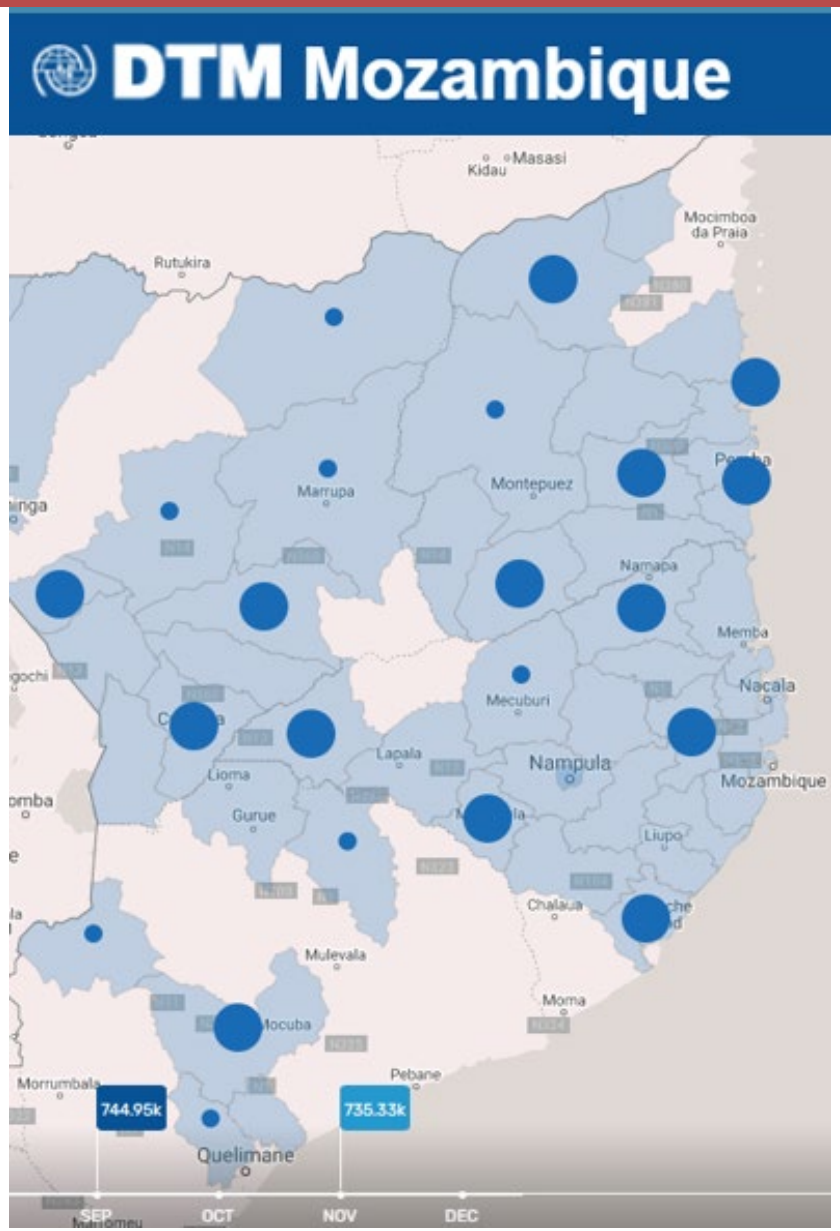
- Update selection criteria to professionalize hiring of Case Managers.
- Update and expand CM mentorship and skill-based training.
- Standardize CM guides & intervention packages, including for ART and TLD transition.
- Increase joint supervision visits with DPS and health facilities (e.g. APS) staff.
- Standardize CM reporting and data triangulation tools.
- Expand the use of community-based advocates and inclusion of beneficiary perspectives for child-protection & oversight.

OVC Program Focus on Most Vulnerable Mothers of HEI & CLHIV



- *Responsive intensity* of CM services for C/ALHIV and caregivers based on needs assessment;
- Focus on identifying and supporting the most challenging C/ALHV cases (low adherence, low viral support); and
- Household-level support to address underlying factors.

Strengthening OVC Case Management for Internally Displaced Persons (IDP)



Source: IOM Displacement Tracking Matrix (DTM) data, November 2021

5,000 IDP-Specific Case Management targets set for COP22

Programmatic Adaptations Planned for IDP:

- Update screening & prioritization criteria
- Create custom indicators to track IDP
- Map existing IDP partners & ensure clear referral systems
- Adapt prevention curriculum & case management packages in IDP districts to ensure appropriate screening & services

Obrigado!

PEPFAR
U.S. President's Emergency Plan for AIDS Relief